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ABSTRACT

The third of four booklets on residential programing for the mentally retarded is intended to help parents evaluate residential services and participate in decisions about program design and implementation. Areas of appropriate program emphasis are indicated for different age groups and for the various degrees of mental retardation from profound to mild. Tasks listed for the preschool aged, school aged, and adults focus on such areas as sensorimotor development and integration, self care, and speech development. General programing principles in the areas of building design, behavioral objectives, training, record keeping, and inservice education are discussed. To show the full range of development within a skill area, stages of the following skills are discussed: eating, dressing, toilet training, bathing, communication, academics, work training, community living, recreation. Special problems of multiply handicapped residents (physical disabilities, epilepsy, visual and aural disabilities) are examined. Check lists are provided for the tasks and skill areas to facilitate evaluation by parents and personnel. For instance, check list items on dressing ask whether residents are encouraged to complete more of dressing tasks until independence is achieved and whether residents participate daily in the selection of clothes to be worn. (For related information, see EC 050 051, EC 050 052, and EC 050 054.) (GW)

RESIDENTIAL PROGRAMMING FOR MENTALLY RETARDED PERSONS

II

Developmental Programming
In the Residential Facility

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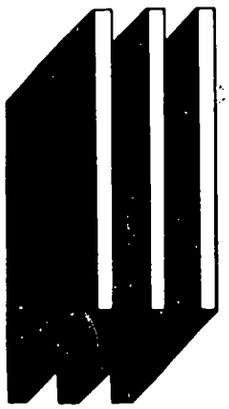
RESIDENTIAL PROGRAMMING FOR MENTALLY RETARDED PERSONS



Developmental Programming
in the Residential Facility

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Developmental Programming in the Residential Facility

There is a growing awareness that many parents are dissatisfied with the services available to their children in residential facilities. However, parents' efforts to remedy existing inadequacies are sometimes seriously hampered by insufficient knowledge of what constitutes desirable programming. The materials that follow (ie., **Suggested Areas of Program Emphasis, General Programming Principles,** and **Specific Skill Areas)** are intended to help parents become increasingly effective as evaluators of residential services and to prepare them for meaningful participation in the decision making process as it relates to program design and implementation. To assist in this regard, check list items are incorporated within the following sections in order to facilitate the evaluation process by focusing attention upon important programmatic aspects. In all cases, a positive answer (i.e., YES) is desirable.

LEVELS OF RETARDATION AND SUGGESTED AREAS OF PROGRAM EMPHASIS

This section describes the four levels of mental retardation and presents suggested areas of program emphasis for different ages and degrees of mental retardation. However, the reader should remember that generalizations regarding ability levels fail to take into account differences among group members. In addition to wide variation among individuals within each level and age group, there are often marked differences in the range of skills exhibited by a given resident, with development being more rapid in some skill areas than in others. Thus, it must be realized that the suggested areas of training emphasis will not be appropriate to the needs of all residents and should not, therefore, be rigidly applied. However, the suggested areas of program emphasis do serve as a point of reference which can be used to evaluate the appropriateness of programs for the individual resident.

Profoundly Retarded Residents

The application of proven training techniques which can markedly improve the overall condition of profoundly retarded persons is still denied to many thousands of institutional residents. It is true that the profoundly retarded represent the most extreme degree of mental retardation (IQ's below 20), accounting for one and one-half percent (1½%) of all mentally retarded persons. However, systematic training efforts have clearly demonstrated that, with exceedingly few exceptions, profoundly retarded persons can profit considerably from training in such areas as self-care, language development, self-protection, impulse control, and physical mobility.

Pre-school Aged Profoundly Retarded Residents. Systematic programming should begin early in the life of profoundly retarded children. If neglected, the marked inactivity and unresponsiveness of profoundly retarded infants can result in secondary physical deformities and establish a pattern of apathy which significantly impedes optimal development at later life stages. Programs for preschool aged, profoundly retarded children should focus upon the prevention of secondary physical handicaps, and lay the foundation for later training in self-care. To counteract these potentially debilitating conditions, it is imperative that profoundly retarded residents be allowed a variety of body positions, receive passive exercise, and move about whenever possible. Moreover, their living environment should include a planned variety of touch, visual stimulation, talk, odors, shared activity, and frequent opportunities for using all senses. The physical surroundings in which residents live should be home-like and offer a variety of out-of-bed areas for eating, toilet use, play, and physical development activities. The overall architectural scheme should incorporate a variety of colors and textures, with appropriate toys, mobiles, wall decorations and other stimuli to interest and attract the attention of young children.

School Aged Profoundly Retarded Residents. If opportunity and encouragement to develop optimally are provided during the first years of life, young school-aged profoundly retarded residents will be prepared for active training in self-care including self-feeding, dressing, bathing, and toilet use. Training programs should also incorporate language development activities, physical fitness, personal control and self-direction. Actually, training progresses on a continual basis from early childhood to school age. As the individual grows, increasing emphasis is placed upon the attainment of specific skills for which foundations were laid in earlier years.

The Profoundly Retarded Adult. The lack of adequate programming for profoundly retarded adults may arise from the belief that learning terminates at adulthood. However, evidence strongly suggests that learning does continue well into the adult years, and that continued training efforts are indeed appropriate. During this period of life, the profoundly retarded adult should be actively encouraged to maintain and refine self-care skills learned as adolescents. Also, a greater emphasis can be placed upon the development of communication skills, physical dexterity, and purposeful use of leisure time. Some profoundly retarded adults can be further trained to perform uncomplicated work tasks in a noncompetitive work activity center.

Table I presents suggested areas of program emphasis for profoundly retarded residents according to age and developmental areas.

Table 1: Suggested Areas of Program Emphasis for Profoundly Retarded Residents

PRE-SCHOOL AGED

Sensori-Motor Stimulation
1. stimulating sight, hearing, touch, smell, and muscular response
2. enriching environment and encouraging exploration of interesting and attractive surroundings

Physical Development
1. body positioning
2. passive exercising
3. rolling, creeping and crawling
4. balancing head and trunk
5. using hands purposefully
6. standing practice
7. training for mobility

Pre-Self Care
1. taking nourishment from bottle and spoon; drinking from cup and finger feeding
2. passive dressing; accommodating body to dressing; partially removing clothing
3. passive bathing; handling soap and washcloth; participating in drying
4. passive placement on toilet; toilet regulating

Language Stimulation
1. increasing attention to sounds
2. encouraging vocalization
3. responding to verbal and non-verbal requests
4. identifying objects

Interpersonal Response
1. recognizing familiar persons
2. requesting attention from others
3. occupying self for brief periods
4. manipulating toys or other objects

SCHOOL AGED

Sensori-Motor Development
1. identifying shapes, colors, sizes, locations, and distances
2. identifying sound patterns, locations, tonal qualities, rhythms
3. identifying textures, weights, shapes, sizes, temperatures
4. identifying familiar, aversive and pleasant odors

Physical Mobility and Coordination
1. practicing ambulation
2. overcoming obstacles; walking on ramps and stairs, running, skipping, jumping, balancing, climbing
3. using playground equipment
4. participating in track and field events

Self-Care Development
1. self-feeding with spoon and cup; eating varied diet; behaving appropriately while dining
2. removing garments, dressing and undressing with supervision; buttoning, zipping, and snapping
3. drying hands and face; partially bathing
4. toilet scheduling; indicating need to eliminate; using toilet with supervision

Language Development
1. recognizing name, names of familiar objects, and body parts
2. responding to simple commands
3. imitating speech and gestures
4. using gestures, words or phrases

Social Behavior
1. requesting personal attention
2. playing individually along side other residents
3. using basic self-protective skills
4. playing cooperatively with other residents

ADULTS

Sensori-Motor Integration
1. sorting, transferring, inserting, pulling, folding
2. responding to music activities, signals, warnings
3. making personal choices and selections
4. discriminating sizes, weights, colors, distances, locations, odors, temperatures, etc.

Physical Dexterity and Recreation
1. riding vehicles; participating in gymnastic-like activities and track and field events
2. marking with pencil; cutting with scissors; stringing beads; pasting; and assembling
3. swimming and water play
4. using community parks, playgrounds, and other recreational resources

Self-Care
1. eating varied diet in family dining situation; using eating utensils; selecting foods
2. dressing with partial assistance or supervision
3. bathing with partial assistance or supervision
4. using toilet independently with occasional supervision

Language and Speech Development
1. listening to speaker
2. using gestures, words, or phrases
3. following uncomplicated directions

Self-Direction and Work
1. using protective skills
2. sharing, taking turns, waiting for instructions
3. traveling with supervision
4. completing assigned tasks
5. participating in work activity center programs

Severely Retarded Residents

Approximately three and one-half percent (3½%) of the estimated 6.1 million mentally retarded persons in the United States are severely retarded. Their pronounced developmental delay is highly similar during early life to profoundly retarded children; however, their rate of progress and developmental potential are significantly greater.

Pre-school Aged Severely Retarded Residents. Since severely retarded infants may experience several years of marked physical immobility and minimal responsiveness to their surroundings, the environment in which they live must include a planned variety of visual experiences, sounds, gentle handling, and other opportunities for residents to use all the senses. They should have a variety of out-of-bed areas for mat or water play, eating, and other daily activities in surroundings furnished with toys, wall decorations, mobiles, and other stimuli to interest and attract the attention of young children. Programming for young severely retarded infants should therefore ensure optimal physical development and provide an environment conducive to learning skills including self-feeding, dressing, bathing, toilet use, language development, and social responsiveness.

School Aged Severely Retarded Residents. Training begun in the pre-school years should be continued on an intensive basis during early school-age in order that severely retarded residents will require less care and supervision from responsible adults. More advanced training in physical development activities, self-care, communication and self-direction can be emphasized during the school-age years.

Severely Retarded Adults. Residential programming for severely retarded adults should provide a socially acceptable pattern of daily living wherein residents can learn to be socially congenial, enjoy the company of other persons, and become useful, well-adjusted members of a family and community. To help them make the transition into adulthood, continued training is required regarding nutrition, personal grooming, hygiene, homemaking skills, self-direction, and work habits. They should be further prepared whenever possible for advanced training in noncompetitive work or sheltered employment.

Behavior appropriate to a variety of social situations should be stressed. In this regard, childlike behaviors such as repetitive handshaking, embracing, giggling, and tantrums particularly should be discouraged.

Table II represents suggested areas of program emphasis for severely retarded residents in relation to age and developmental areas.

Table 2: Suggested Areas of Program Emphasis for Severely Retarded Residents

PRE-SCHOOL AGED

Sensori-Motor Development
1. stimulating sight, hearing, touch, smell, and muscle response
2. identifying shapes, colors, locations and distances
3. identifying sound patterns, locations, tonal qualities, and rhythms
4. identifying textures, weights, shapes, sizes and temperatures
5. identifying familiar, aversive, and pleasant odors
6. defining body location and boundaries

Physical Mobility and Coordination
1. passive exercising and body positioning
2. rolling, creeping, and crawling
3. balancing head and trunk
4. using hands purposefully
5. practicing ambulation
6. overcoming obstacles; using stairs, ramps, and balancing

Self-Care Development
1. taking nourishment from bottle and spoon; drinking from cup and finger feeding; partial self-feeding with spoon and cup
2. accommodating body to dressing; partially removing clothing; removing clothing and dressing with assistance
3. handling soap and washcloths; participating in drying; drying hands and face; partially bathing
4. scheduling toilet use; indicating need to eliminate

Language and Speech Development
1. increasing attention to sounds and voices
2. encouraging vocalization
3. recognizing name, names of familiar objects, and body parts
4. imitating speech and gestures
5. using gestures, words and phrases

Social Behavior
1. recognizing familiar persons
2. requesting personal attention
3. occupying self for brief periods
4. playing independently along side other residents

SCHOOL AGED

Sensori-Motor Integration
1. sorting, transferring, pulling, and folding
2. responding to music activities, signals and warnings
3. making personal choices and selections
4. discriminating sizes, weights, colors, distances, temperatures, locations, and basic similarities and differences

Physical Dexterity and Recreation
1. running, skipping, jumping, balancing, climbing
2. using indoor and outdoor play equipment
3. using riding vehicles; participating in gymnastic-like activities, track and field events
4. participating in uncomplicated group games and sporting events

Self-Care
1. self-feeding with spoon and cup; eating varied diet in family-style dining situation; using utensils appropriately; behaving acceptably during meals; and selecting foods
2. dressing and undressing with supervision, buttoning, zipping, snapping, lacing and tying; selecting appropriate clothing items with supervision
3. bathing with partial assistance and supervision; using comb and brush
4. using toilet independently; self-wiping, etc.

Speech Development
1. using gestures, phrases, and sentences to express needs
2. asking for the names of objects
3. using descriptive and action words; using pronouns; expressing feelings and sensations
4. following verbal directions
5. understanding relationships such as "up-down", "over-under", "big-little", etc.

Social Behavior and Self-Direction
1. using self-protection skills
2. sharing, taking turns, and waiting for instructions
3. imitating adults through playing dress-up, tea party, store, etc.
4. going about surroundings unsupervised
5. acquiring basic housekeeping skills

ADULTS

Sensori-Motor Integration
1. recognizing essential similarities and differences
2. using plans of search
3. using time and place concepts
4. recognizing potential dangers; obeying traffic lights, stop signs, and other warning devices
5. using visual and auditory memory skills

Recreation and Leisure Activities
1. using community recreation facilities such as theatres, parks, zoos, swimming pools, bowling alleys, etc.
2. exercising for muscle tone and weight control
3. observing or participating in sports
4. attending club meetings, dances, and other social activities involving both sexes

Self-Care, Grooming and Hygiene
1. dining in family or community settings; selecting a normal diet; and maintaining weight control
2. selecting appropriate clothing, normal hair and clothing styles; caring for personal clothing items
3. caring for hair, teeth, nails and shaving or menstrual needs; using cosmetics and deodorants

Communication
1. relating experiences and feelings verbally
2. following directions requiring performance of several tasks
3. repeating messages and giving simple directions to others

Self-Direction and Work
1. behaving like adults in a variety of social situations
2. using public transportation with supervision
3. practicing homemaking skills
4. participating in work activity center programs

Moderately Retarded Residents

Moderately retarded persons account for approximately six percent (6%) of the retarded population, having Stanford-Binet IQ's from 36 to 51. Early training is essential to ensure optimal functioning in later life. In the last decade, increasing emphasis has been placed upon the role of families, public schools, and community agencies in the training and habilitation of moderately retarded persons. Resulting opportunities for community based training, created by this new emphasis, have shown that moderately retarded citizens can live acceptably in community group homes and make valuable social and occupational contributions through employment in sheltered workshops or other supervised work settings.

Pre-school Aged Moderately Retarded Residents. The developmental delay exhibited by moderately retarded children is not as pronounced as with profoundly and severely retarded persons. However, their unusual slowness in regard to sitting alone, standing, walking, and learning to talk will be obvious to most parents. As they grow older, the pre-school aged, moderately retarded resident will be more like a child than an infant. They will be walking, running, climbing and attempting to use language. Although the residents may have a limited expressive vocabulary, they will learn to understand other persons' speech. Toilet use, simple dressing, self-feeding, and participation in the bathing process should be proceeding rapidly by the time they reach school age, and the residents should be exhibiting increasing degrees of social cooperativeness.

School Aged Moderately Retarded Residents. School and living unit training programs for school aged residents should focus upon personal grooming and hygiene, self-direction, practical reading and writing, safety, communication, social adjustment, physical fitness, use of leisure time, homemaking, pre-work training, and pre-work experiences. In this regard, school and living unit programs must be closely integrated in order to make training highly relevant to daily life. Classroom instruction for young residents may be conducted in their living units or in a more traditional classroom setting; however, as the moderately retarded residents grow older, a community-based school classroom is preferable.

Moderately Retarded Adult Residents. Community programs have shown that moderately retarded citizens have considerable potential for occupational productivity and adjustment to sheltered community living. During adulthood, moderately retarded residents need additional training to prepare them for life in community group homes and for employment in sheltered workshops or the production of salable items. Unfortunately, training is frequently terminated for the majority of moderately retarded residents of large, publicly supported institutions when the residents achieve adulthood. All too often they are allowed to become overweight, physically debilitated, and bizarre regarding behavior and personal appearance. Hopefully, this trend will be reversed in the light of current emphasis upon establishing sheltered workshops and community group homes as workable alternatives to prolonged confinement in traditional residential facilities.

Table III presents suggested areas of program emphasis for moderately retarded residents according to age and developmental areas.

Table 3: Suggested Areas of Program Emphasis for Moderately Retarded Residents

PRE-SCHOOL AGED

Sensori-Motor Development

1. stimulating senses; recognizing shapes, colors, locations, distances, temperatures, and basic similarities and differences
2. identifying sound patterns, sound locations, tonal qualities, rhythms
3. discriminating textures, weights, shapes, sizes
4. identifying familiar, aversive, and pleasant odors
5. responding to music, signals, and warnings

Physical Mobility and Coordination

1. rolling, creeping, and crawling
2. balancing head and trunk; purposefully using hands; training in ambulation; overcoming obstacles, using stairs and ramps
3. balancing, running, skipping, jumping, climbing
4. riding vehicles
5. using standard playground equipment
6. marking with pencils and crayons; stringing beads, and cutting with scissors

Self-Care

1. drinking from a cup and finger feeding; self-feeding with spoon and cup; and eating varied diet in family-style dining situation
2. removing clothing with assistance; removing clothing; dressing with assistance; uncomplicated buttoning, zipping, etc.
3. drying hands and face; partially washing self; bathing with assistance; experimenting with comb and brush
4. scheduling toilet use; indicating need to eliminate; using toilet independently

Speech Development

1. recognizing names of familiar objects, own name, and body parts
2. imitating speech and gestures
3. responding to simple commands
4. using gestures or words to express needs
5. following verbal directions
6. using simple action and descriptive words

Social Behavior

1. requesting personal attention
2. playing independently along side other residents
3. using self-protective behaviors
4. sharing, taking turns and waiting for instructions
5. imitating adults through play activities
6. going about surroundings unsupervised

SCHOOL AGED

Sensori-Motor Integration

1. recognizing essential similarities and differences
2. searching for hidden articles
3. using time and place concepts
4. using visual and auditory memory skills
5. becoming aware of potential dangers; obeying traffic lights and other warning devices
6. discriminating sizes, weights, colors, distances, locations, odors, temperatures, etc.

Physical Dexterity and Recreation

1. participating in calisthenics, gymnastic-like activities, and track and field events
2. drawing, painting and craft activities
3. using standard playground equipment
4. using community recreation facilities such as theatres, parks, zoos, bowling alleys, etc.
5. attending club meetings, dances, and other activities involving both sexes

Self-Care, Grooming, and Hygiene

1. eating varied diet in family-style dining situation; using utensils appropriate to community and family dining; selecting foods; preparing basic meals; acquiring proper dietary habits
2. dressing with supervision; selecting appropriate clothing; maintaining current hair and clothing styles; caring for personal clothing items and clothing details
3. bathing with supervision; using comb and brush; caring for hair, teeth, nails, and shaving or menstrual needs; using cosmetics and deodorants
4. using toilet independently

Communication

1. using descriptive, action, and relationship words
2. expressing feelings and sensations verbally
3. relating experiences; repeating a message; and giving simple directions to others
4. reading words relative to safety and independence
5. writing name and other words of practical significance

Self-Direction and Pre-Work Skills

1. behaving appropriately in a variety of social situations
2. traveling supervised in community
3. practicing homemaking skills
4. using public transportation
5. acquiring attitudes, habits, and skills related to work

ADULTS

Sensori-Motor Integration

1. acquiring proficiency in sorting, collating, packaging, wrapping, operating levers, and mechanical apparatus
2. cleaning, repairing, assembling, refinishing
3. understanding time, location, distance, height, weight, temperature, volume as related to work.
4. operating machinery and using tools

Recreation and Leisure Activities

1. using community recreation facilities such as theatres, parks, zoos, bowling alleys, etc.
2. observing or participating in sports
3. exercising for muscle tone and weight control
4. attending social clubs, dances, camping, trips of interest, and other recreative activities involving both sexes

Self-Care, Grooming and Hygiene

1. dining in public restaurants and cafeterias; preparing simple meals; practicing dietary variety and nutritional habits
2. improving personal appearance; dressing appropriately to nonretarded peers; caring for and purchasing personal clothing items
3. caring for hair, teeth, nails and other details of personal hygiene

Communication

1. using correct speech volume and enunciation
2. following instructions involving several assignments
3. communicating name, address, and telephone number
4. writing name and other simple words legibly; reading traffic signs, labels on packages, telephone numbers, signs of information
5. counting, making change
6. concentrating on topic; organizing thoughts and relating experiences in sequential form

Self-Direction and Work

1. cleaning and maintaining residence
2. using community shops and stores
3. using public transportation facilities
4. knowing laws and rules of community
5. budgeting and saving
6. developing amenability to supervision, perseverance, and other job behaviors and attitudes
7. participating in productive sheltered employment

Mildly Retarded Residents

Mildly retarded persons are highly similar to their nonretarded peers, differing primarily only in rate and degree of intellectual development. While still young, their retardation is not readily apparent, and children are not usually identified as retarded until they enter public school. During adulthood, they again tend to lose their identity as mentally retarded when they are absorbed into the competitive labor market and daily community life.

Approximately eighty-nine percent (89%) of this country's mentally retarded citizens are mildly retarded, having Stanford-Binet IQ's of 52 to 67. Programming for all ages of mildly retarded residents — up to and including adulthood — should be designed to maximize social, educational, and vocational skills relevant to independent community living and gainful employment.

Pre-school Aged Mildly Retarded Residents. Considerable evidence suggests that appropriate early education programs during pre-school years are particularly critical for later development. Neglect of children's handicapping conditions during this period can lead to irreversible damage which significantly interferes with later remedial action. Pre-school programs should emphasize a variety of perceptual, cognitive, and social learning experiences combined with self-care, language and physical development.

School Aged Mildly Retarded Residents. School aged mildly retarded residents should be enrolled in appropriate school classes, preferably in the community public school systems. This holds true even though students may be residents of institutions. Students may receive basic instruction in special classes, and also take part in the regular school program in specific curricula areas. Attendance in community-based schools is an important means of easing the later adjustment to community living and work. Moreover, the education curricula for mildly retarded school age residents should be directly related to the problems residents will likely encounter in independent living situations. Such curricula might include personal grooming and hygiene, safety, oral and written communication, number concepts, housekeeping skills, nutrition and food preparation, sex education and pre-vocational work skills.

Mildly Retarded Adults. With proper training in early life, the vast majority of mildly retarded persons can live successfully, either singly or married, in apartments or homes in the community. Their chances for vocational success have also increased considerably in recent years through on-the-job training programs and expanded federal vocational rehabilitation services including vocational evaluation, training, placement and followup.

Cooperative relationship between vocational rehabilitation offices and the public schools are further aiding a more satisfactory transition from school to work.

Although the mildly retarded have a high potential for successful independent living and employment in the competitive labor market, they frequently are not prepared adequately for the responsibilities of life in the community. Therefore, continuing adult education programs are required to ensure that the mildly retarded become well adjusted, contributing members of society.

Table 4: Suggested Areas of Program Emphasis for Mildly Retarded Residents

PRE-SCHOOL AGED

Sensori-Motor Development
1. listening to and recognizing sounds
2. sorting objects by color, size and shape
3. identifying patterns, sound locations, tonal qualities, and rhythms
4. discriminating between colors, textures, weights, shapes, temperatures, locations, odors, distances
5. using visual and auditory memory
6. searching, identifying, and pointing out similarities and differences
7. using time and place concepts

Physical Mobility and Coordination
1. overcoming obstacles; balancing, running, skipping, jumping and climbing
2. riding vehicles and using standard playground equipment
3. marking, coloring, pasting, cutting, stringing, and transferring

Self-Care
1. feeding self with fingers, spoon, cup, and other eating utensils; eating varied diet in family-style dining situation; dining in undisruptive manner
2. removing clothing and dressing with assistance; buttoning, zipping, lacing, and simple tying; wearing a variety of clothing; hanging or storing clothing when not in use
3. drying face and hands; washing self with assistance; using comb and brush
4. indicating need to eliminate; using toilet independently; wiping self, etc.

Speech Development
1. recognizing name, names of familiar objects and body parts
2. imitating speech and using single words
3. responding to verbal requests
4. following verbal instructions
5. listening to speaker
6. using action, descriptive, and relationship words
7. expressing feelings, sensations, and experiences

Social Behavior
1. requesting personal attention
2. occupying self unattended
3. playing independently along side other residents
4. sharing, taking turns, and waiting for instructions in play activities
5. using self-protecting behaviors
6. imitating adults through play
7. going about surroundings with minimal supervision

SCHOOL AGED

Sensori-Motor Integration
1. recognizing essential similarities and differences
2. using visual and auditory memory skills
3. understanding time, location, distance, height, weight, temperature and volume
4. responding to music, dancing and singing
5. operating vehicles and machinery
6. using tools

Physical Dexterity and Recreation
1. participating in calisthenics, gymnastics, and organized sports
2. using community recreation facilities such as theatres, parks, zoos, bowling alleys, etc.
3. attending social clubs, dances; camping, trips of interest, and recreative activities involving both sexes
4. participating in arts and crafts; painting, molding, etc.

Self-Care, Grooming, and Hygiene
1. using appropriate eating utensils; eating in public restaurants and cafeterias; preparing meals; practicing dietary variety and nutritional habits
2. improving personal appearance; wearing dress and hair styles appropriate to nonretarded peers; selecting, purchasing, and caring for clothing items
3. caring for hair, teeth, nails, and other details of personal hygiene including shaving or menstrual needs
4. using toilet independently

Communication
1. listening to and following instructions; sharing experiences verbally, waiting turn to speak; using proper voice volume and rate
2. asking and answering questions
3. organizing thoughts before speaking and relating experiences in sequential form
4. reading and writing appropriate to interest and ability level
5. using basic number concepts including fractional parts, making change, measuring, telling time, etc.
6. being aware of current events; practicing conversational skills; and using telephone

Self-Direction and Pre-Work
1. learning courtesy, manners, meaning of responsibility, truthfulness, dependability, and acceptance of criticism
2. understanding sexual behavior
3. participating in pre-vocational evaluation and job sampling; learning work attitudes and behaviors
4. homemaking activities and responsibilities
5. using public transportation, shops, stores, and other community facilities
6. knowing laws and rules of community
7. working part-time
8. budgeting, saving, and proper use of money
9. recognizing, reporting and correcting hazards

ADULTS

Sensori-Motor Integration
1. acquiring work related skills involving movement, balance, coordination and use of all senses
2. increasing proficiency in discriminating time, location, distance, height, weight, temperature, volume, and position
3. operating motor vehicle, equipment and machinery

Recreation and Leisure Activities
1. using community recreation facilities such as theatres, parks, zoos, bowling alleys, etc.
2. attending social clubs and dances; camping, trips of interest, and recreational activities involving both sexes
3. developing skills related to crafts, music appreciation, and fine arts
4. observing or participating in sporting events

Self-Care, Grooming and Hygiene
1. Maintaining balanced diet; preparing meals; behaving appropriately in a variety of dining situations
2. knowing clothing styles appropriate for a variety of social, work, seasonal, and climatic conditions; care of personal clothing items

Communication
1. reading newspapers, magazines, menus, application forms, etc.
2. using public communication media and public libraries
3. communicating with counselors, advisors and other persons associated with social welfare, medical, legal, and vocational agencies
4. writing letters and checks; making purchases by mail; completing social security, insurance, medical, and other forms
5. interviewing for job

Community Living and Work
1. locating a residence; assuming financial responsibility associated with residence
2. practicing homemaking skills and responsibilities
3. understanding responsibilities related to marriage, parenthood and the use of birth control techniques
4. participating in vocational counseling and placement, on-the-job training, and job selection
5. practicing citizenship skills including voting, obeying laws and participating in community affairs

GENERAL PROGRAMMING PRINCIPLES

There are general program principles which are applicable in all areas of residential programming. These principles are dealt with separately here since they apply to all skill areas which will be subsequently discussed. For example, training in all areas requires the development of specific behavioral objectives by individual residents. The reader should bear these general principles in mind when considering each skill area.

The design, construction and furnishing of resident living units should simulate those elements found in a typical home in the community. Clearly distinguishable areas should be available for sleeping, dining, toileting, and leisure activity, both for group and individual residents. Additionally, private areas should be available where residents can engage in solitary activities when not involved in scheduled programs.

Although many existing residential facilities were originally designed to accommodate large groups of residents without regard for privacy and individual needs, these custodial structures have been modified in many cases to simulate home-like living conditions. Such overall restructuring usually necessitates the decentralization of large storage areas, dayrooms, dining and sleeping areas. For example, large bedroom areas have been subdivided into sections accommodating one to four residents by using partitions extended from floor to ceiling. Chests of drawers, desks and tables, wall decorations, closets, and shelving have been added to these small, semi-private sleeping areas to make them home-like and conducive to individualized living patterns. Day room areas have also been modified using room dividers, curtains, furniture groupings, varied color schemes, and wall decorations. Items such as table lamps, carpets, and tables with center pieces have even been used in residences for profoundly retarded children.

Yes	No	
☐	☐	**Does the living unit have distinct, home-like areas for sleeping, dining, toileting, and leisure activities which are conducive to privacy and individual living patterns?**
☐	☐	**Are furnishings throughout the living unit similar to those found in homes in the community?**
☐	☐	**Are residents permitted individual furniture with provisions for storage of personal possessions?**

An important first step in designing residential training programs is to clearly define and record behavioral objectives for each resident. These objectives should be developed by a multidisciplinary team comprised of professional and non-professional staff who are

assigned ongoing responsibility for a given group of residents. The objectives should be stated in precise language to facilitate objective measurement and evaluation. Thus, the objective of "improving the resident's eating skills" is too general for meaningful evaluation. A more appropriate statement might be "the current goal for the resident in the area of eating skills is to teach him to independently use a spoon and cup".

The objectives which are established in a given area of training should reflect the resident's current level of competency in that area, and should be aimed at increasing his competency according to a logical developmental sequence. For example, an appropriate objective for a child who has begun finger-feeding is self-feeding with a spoon, whereas an inappropriate objective would be to develop skills in the area of family style eating — when the resident has not yet learned to use a fork and knife. Training objectives should also have practical relevance for later learning experiences (e.g., in school, home, and community). It is particularly critical that parents become actively involved in goal-setting, in order to ensure the relevance of goals to practices in the resident's home and surrounding community.

Yes	No	
☐	☐	**Are objectives established by a multidisciplinary team comprised of professional and non-professional staff who work directly with the resident?**
☐	☐	**Are objectives stated in precise and measurable terms?**
☐	☐	**Are objectives realistic in terms of the resident's current level of competency?**
☐	☐	**Do established objectives have practical relevance? Are parents involved in the process of establishing objectives?**

There should be a written plan for each resident detailing specific training strategies planned for achieving stated objectives. This plan should include detailed schedules of daily training activities. A simple statement that "during the day the resident will be trained in eating, dressing, and toileting skills" is insufficient, and does not establish the basis for sytematic programming. Rather, the written training plan should indicate specific program activities and times (e.g., "from 10:00 - 10:30 a.m. a particular member of the living unit staff will work with the resident on an individual basis, to increase his ability to put on and remove his clothes"). It is vitally important that schedule continuity is maintained between shifts. Brief daily meetings at the time of shift change should focus on

the progress of individual residents.

Training may be accomplished in an individual or group setting. Thus, training in basic dressing skills should be accomplished on a one-to-one basis, while training in acceptable table manners may be accomplished on a small group basis in the dining room.

In group training activities, residents should be grouped according to specific training needs, rather than on the basis of overall functioning levels. For example, severely and profoundly retarded residents with comparable eating skills may be trained together in a common dining group. Grouping should also be flexible enough to allow the resident to take part in different groups for different types of training. Thus, there should be mobility from group to group within the living unit as well as among groups on different living units.

Interdepartmental cooperation is critical to the establishment of training schedules for sound resident-oriented programming. For example, due to variation among the facility's residents in self-feeding competency, it would be highly undesirable for the food service department to establish the same feeding schedule for every living unit (i.e., training in the area of eating skills will require more time on some units than on others). There must also be close coordination among all departments involved in training a particular resident. Thus, in the case of a mildly retarded adolescent who is involved in a work training program, there must be ongoing communication regarding behavioral objectives and training techniques among personnel from such departments as the academic school, the living unit, and the supervisor of the resident's on-campus job placement.

An adequate number of personnel should be provided to effectively implement each training activity. The staff to resident ratio on the unit should thus vary according to the training activity. Assignments should be sufficiently flexible to allow personnel to work on more than one living unit during a given shift.

A representative of the multidisciplinary team should keep parents fully informed of their child's participation in a particular training program. Information should include specific techniques being used, so that parents can use comparable training approaches when the resident is at home. Failure to achieve such parent-staff coordination often results in the utilization of incompatible training techniques which impede progress or undo learning which has been achieved in the residential setting.

	Yes	No	
14	☐	☐	**Is there a written program plan for each resident?**
	☐	☐	**Does the plan include a detailed schedule of training activities?**

Yes	No	
☐	☐	Is individual training afforded in areas which necessitate close supervision?
☐	☐	Are inter-shift meetings held to ensure continuity in living unit training programs?
☐	☐	Are training groups formed on the basis of individual program needs?
☐	☐	Is grouping sufficiently flexible to allow residents to be in different groups for different training activities?
☐	☐	Are training programs facilitated by a high degree of interdepartmental cooperation?
☐	☐	Are there adequate numbers of direct care staff to conduct a comprehensive training program?
☐	☐	Are all persons involved in training familiarized with individual behavioral objectives and training techniques?
☐	☐	Are parents kept fully informed of programs and techniques so that complementary home programs can be established?

Individual records should be kept for each resident reflecting his progress in achieving the specific behavioral goals which have been established. Progress should be measured through objective means (e.g., rating scales developed to reflect increasing competency in specific areas of training).

Professional and non-professional staff should meet regularly to evaluate each resident's progress in attaining established training objectives. On the basis of these meetings, modifications in both objectives and techniques may be made to reflect the resident's programming need (e.g., experience in the training program may indicate that the programming is being conducted at too low a level, or that the techniques used are not the most effective in assisting the individual to obtain desired levels of competency). In the evaluation process, communication among living unit personnel on different shifts is particularly critical.

Parents should be actively involved in the training process in terms of determining: (1) the extent to which skills learned in the residential facility are carried over into the home setting; and (2) the relevance of these skills to demands in the home and in the community in which the resident and his family live.

A follow up evaluation should be conducted after the resident has been discharged from the institution. This extension of the evaluation process will fulfill two purposes: (1) it may assist in identifying areas in which the resident is having difficulties in adjusting to community placement, thereby highlighting supportive services which may be required; and (2) it will enable the staff of the residential facility to determine the appropriateness of training goals and procedures in terms of the daily living requirements in the community.

Yes	No	
☐	☐	Are individual records maintained which indicate objective measurement of progress?
☐	☐	Are there regularly scheduled meetings of professional staff to evaluate resident progress?
☐	☐	Do the results of such meetings serve to modify the objectives and techniques for individual programs?
☐	☐	Are daily records discussed among shifts?
☐	☐	Are parents involved in the evaluation process?
☐	☐	Are skills taught relevant to the home and community setting?
☐	☐	Are post-discharge follow up evaluations conducted?

Professional staff should be involved in activities which have direct relevance to the programming needs of the resident. For example, a psychologist assigned to a multidisciplinary team should focus upon developing individual training schedules, implementing programs and evaluating outcomes, rather than upon routine psychometric evaluations. Such duties may be assigned to lesser trained staff.

Inservice education is critical to the implementation of sound resident training programs. Inservice programs should focus upon content areas directly related to resident training needs (e.g., child development, specific training techniques such as behavior modification, etc.). Such training should be provided for all levels of staff (professional and non-professional) and all departments that have any contact with residents. Thus, if work training is conducted by personnel in the facility's maintenance department, it is important

that these individuals are given intensive training in resident needs and training techniques.

Inservice education should be an ongoing process rather than an activity confined to the worker's initial month of employment. The curriculum for the inservice education program should not be the same from year to year, but should change according to feedback regarding the relevance and effectiveness of content areas in achieving actual resident training goals. The ultimate test of the effectiveness is not expressed satisfaction on the part of personnel, but progress made by residents.

A major problem in many residential facilities is that available resources, including the time of professional and non-professional staff, are not used to maximum advantage. In order to obtain maximum effectiveness from available resources, all personnel having supervisory responsibilities (from the living unit supervisor to the superintendent) should be provided with training in the basics of effective management. A variety of sound management training programs are currently available from established management training firms, university schools of business administration, etc.

Yes	No	
☐	☐	**Are professional staff actively involved in resident programming?**
☐	☐	**Are inservice training programs directly related to resident training needs?**
☐	☐	**Are all levels of staff who have contact with residents required to participate in inservice training?**
☐	☐	**Is inservice training curriculum evaluated in terms of its effectiveness in achieving stated resident training objectives?**
☐	☐	**Is management training afforded all staff having supervisory responsibilities?**

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SPECIAL SKILL AREAS

When we speak of development we are referring to the progressive acquisition of many abilities such as academic skills, physical mobility, independence in self-care, work proficiency, independent living skills, and leisure activities. Residents can be expected to achieve varying degrees of proficiency in each of these skill areas. Moreover, there will be considerable variability evident between residents in each skill area, regardless of degree of mental retardation, as well as within an individual resident's range of abilities.

In this section, skill areas will be discussed separately to show the full range of development within a given skill area. The reader must clearly understand that not all residents will progress to all levels of competency. Thus, some portions of each skill continuum will not be applicable to a particular group or individual resident. In this regard, the reader should refer to the previous section on **Suggested Areas of Program Emphasis** for the various ages and degrees of mental retardation.

SPECIAL SKILL AREAS

EATING SKILLS

In the development of eating skills, a nonretarded child proceeds through passive bottle or breast feeding in conjunction with pureed foods, finger feeding and taking liquids from a cup and straw, using utensils with assistance, self-feeding with a spoon and drinking with a cup and, finally, behaving acceptably in a family-style dining arrangement or public eating facility. During later stages of development, the skills required to purchase and prepare food are developed. The retarded persons should be provided with the opportunity to progress as far as possible along this line of behavior.

Among a relatively small group of profoundly retarded children, neuromuscular difficulties may result in severe feeding problems. There has been a tendency in the institutional setting to attempt to compensate for severe feeding problems by the use of gavage techniques (i.e., inserting a tube through the nose and into the stomach). Although this is a valid emergency measure to ensure adequate nutritional intake on a temporary basis, it has too often become a permanent approach to children with feeding problems. Gastric fistula (i.e., tubes inserted directly through the abdomen wall into the stomach) are also used in some cases. This approach is justified in an even smaller number of cases involving rare physiological anomalies.

A retarded person who is consistently tube fed is deprived of the opportunity to develop the oral mechanism and is thus unable to develop proper breathing and swallowing patterns. Additionally, he is constantly threatened with aspiration pneumonia. The retarded individual is also deprived of the opportunity to develop speech, since feeding patterns are closely related to speech production. Finally, tube feeding causes the retarded person to be viewed as "sick". He is ordinarily confined to a bed, with little opportunity to explore his environment and learn more advanced motor patterns.

Recognizing that there are possible exceptions to the rule, it has been adequately demonstrated that profoundly involved youngsters can be helped to develop adequate tongue, lip and breath control which allows them to accept food in a normal manner. In those instances where tube feeding is used, the resident's medical records should contain thorough documentation of his inability to obtain nourishment through other means.

There are a number of facilitation techniques which involve the step-by-step stimulation of the lips and tongue to teach proper muscle control. There are also techniques which teach proper breath control to permit swallowing and, ultimately, chewing behavior. Often, the child must be taught how to suck properly before he can take food from a bottle. These techniques should be incorporated in a systematic program to wean residents from feeding tubes.

The extra efforts involved in helping develop proper feeding habits are more than justified by the substantial gains which result

from freeing the resident from an abnormal reliance on tube feeding.

Yes	No	
☐	☐	**Is the need for the tube feeding supported by evidence in the resident's medical records?**
☐	☐	**Is there a systematic program for weaning residents from feeding tubes?**

With few exceptions, a child should be approaching a normal diet by the time he is eighteen months old. Thus, residents eighteen months or older who receive nourishment by bottle should also be given soft foods. Residents should be fed in an upright position. When head and trunk balance are achieved and there is evidence of finger feeding, individual training sessions in the use of spoon and cup should be incorporated into the resident's daily program. These individual sessions, sometimes referred to as "pudding sessions" can consist of supplementary "meals" using foods that readily adhere to a spoon. This establishes basic hand to mouth movements, and allows practice in filling the spoon and maintaining a proper hand position to minimize spillage. The direct care person begins the feeding activity by filling the spoon and guiding the resident's hand toward his mouth. The resident is allowed to progressively accomplish more of the feeding task without assistance until he is able to fill the spoon and feed himself independently. A number of techniques may be utilized to assist those residents who are unable to hold a spoon or cannot execute the wrist motions needed to turn the spoon toward their mouth. If the resident has difficulty in holding a spoon, it may be affixed to his hand or a spoon with a specially built-up handle may be provided. Limited wrist motion is sometimes compensated for by a swivel spoon, although the same result may usually be obtained by simply bending an ordinary spoon.

Yes	No	
☐	☐	**Is bottle feeding supplemented by soft foods?**
☐	☐	**Are residents in an upright position when fed?**
☐	☐	**Are "pudding sessions" used to increase eating skills?**
☐	☐	**Are special techniques used in feeding to compensate for difficulties in holding or turning a spoon?**

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When residents have learned the basic movements of self-feeding, they can be assigned to small dining groups, preferably not exceeding four residents per group. The dining area should be pleasant and home-like. Two direct care personnel and/or volunteers will be needed initially to supervise meal sessions. Only one person will be required as residents attain increased proficiency. Sufficient time should be allowed for dining to enable each resident to feed himself at a reasonable pace. Dining tables and chairs should be appropriate to the resident's physical requirements (e.g., young residents will require smaller scale furniture; residents in wheelchairs will need ample space to allow them to sit close to the table). Residents should be given a variety of foods at different textures and temperatures. Even when spoon feeding is being emphasized, finger foods such as bread should be provided. At this stage, training personnel should begin to teach residents to eat in a nondisruptive manner by discouraging such behaviors as grabbing for food, getting up from the table to walk about the room, fighting, etc. This **does not** mean that talking or nonverbal communication should be forbidden.

Yes	No	
☐	☐	**Are residents assigned to small dining groups?**
☐	☐	**Is the dining room pleasant and home-like?**
☐	☐	**Are sufficient personnel available to ensure that effective training occurs?**
☐	☐	**Do residents have sufficient time to feed themselves?**
☐	☐	**Is furniture appropriate to resident needs?**
☐	☐	**Are a variety of foods provided?**
☐	☐	**Is appropriate dining room behavior encouraged?**

Having learned to manipulate a spoon and cup, residents should be encouraged to use the full range of eating utensils. "Resident safety" is sometimes used as the justification for failing to provide knives at mealtimes. Such an overly protective attitude only serves

to prevent the resident from developing socially acceptable eating patterns. In addition to basic eating utensils, table cloths, napkins, condiment dispensers and other accouterments associated with family-style eating should be provided. Residents should be taught to take bite-sized portions, eat at a normal pace, and chew their food adequately. Residents should be given assistance in learning to cope with increasingly difficult foods (e.g., mashed potatoes may be eaten with a spoon, while french fries require the use of a fork; hamburger patties may be cut with a fork, while cutting steak requires a knife). Training in mealtime behavior should focus upon teaching proper eating habits such as taking a variety of foods and avoiding over or under eating. Residents should learn what foods are commonly eaten at each meal, and the essentials of proper table manners. At this stage, residents may be given increasing latitude with regard to the foods they eat and the size of their portions. An initial step may be cafeteria style eating, where the resident can select from a variety of foods which are apportioned by a staff member. A more advanced step is family-style eating. Here the resident may select the foods he desires and the size of his portions from platters and bowls placed upon the table.

Yes	No	
☐	☐	**Are residents given the opportunity to use a variety of eating utensils, including knives?**
☐	☐	**Are tablecloths, napkins, etc. provided?**
☐	☐	**Is training provided in such areas as speed of eating, thorough chewing, over and under eating and appropriate table manners?**
☐	☐	**Are residents given increasing latitude in selecting types of foods and portion size?**

Upon developing the eating skills outlined above, mentally retarded persons should be provided with further training to enable them to function in the community on an independent or semi-independent basis. The fundamentals of good nutrition should be taught so that the resident will know what constitutes an adequate diet. Mentally retarded persons should be taken on frequent trips to a variety of restaurants in the community and be taught to select a well balanced meal from a menu. The resident should be taught how to interact with waiters and waitresses, including accepted tipping practices. Increasing self-direction, includng unsupervised eating in restaurants, should be encouraged. Both male and female residents should be trained in purchasing foods and preparing

simple meals, since they will probably be required to cook for themselves later in life. Shopping trips to grocery stores should be included in the training program, ultimately leading to independent purchasing. Food preparation skills may be introduced early in the academic school program. Opportunities to participate in food preparation in the living unit should also be provided.

Yes	No	
☐	☐	**Are the fundamentals of good nutrition taught?**
☐	☐	**Are residents given the opportunity to learn to eat in community restaurants?**
☐	☐	**Are residents taught to purchase food in the community?**
☐	☐	**Are residents taught to prepare simple meals?**

There are a number of basic principles which apply to all stages in the development of eating skills. Frequently, the scheduling of meals is based upon staff convenience rather than upon resident needs. Meals should, however, occur at reasonable times of the day which approximate "normal rhythms" found in the community. There is a large body of literature available which clearly describes systematic procedures for teaching self-feeding. These materials should constitute an important part of inservice education programs offered to direct care personnel. Persons other than institutional staff (e.g., volunteers or other residents) who are involved in resident feeding, should be properly trained and supervised. Each resident's eating skills should be evaluated and programs should be designed to help the resident develop toward greater independence. Individual records should be kept to determine progress and to evaluate the appropriateness of specific training strategies. Clear cut criteria and evaluative mechanisms should be incorporated to determine readiness for a more advanced eating program. Without such criteria, residents may be allowed to remain in a program which is well below their potential for achievement. All residents, including the mobile non-ambulatory, should be fed in dining rooms unless contraindicated by health reasons. The mealtime atmosphere should be relaxed, warm, and conducive to learning. Personnel responsible for supervising self-feeding programs should react differently to each resident, according to individual levels of competency.

Yes	No	
☐	☐	Are meals scheduled at reasonable times of the day?
☐	☐	Are direct care staff trained to teach self-feeding skills?
☐	☐	Are non-staff persons involved in feeding properly trained and supervised?
☐	☐	Are feeding programs designed to meet resident needs?
☐	☐	Are progress records kept?
☐	☐	Are there specific criteria for determining readiness for a more advanced feeding program?
☐	☐	Are residents fed in a dining room setting?
☐	☐	Is the mealtime atmosphere conducive to learning?
☐	☐	Do personnel react to residents according to individual abilities and needs?

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DRESSING

Dressing is one of the more complex skills which requires many sequential movements and involves gross and fine coordination, eye-hand coordination, and balance. If, for example, the movements involved in removing one of the simplest garments (e.g., a loose-fitting pullover sweat shirt) are indivdually counted, it is obvious that a great number of sequential movements are required in even basic dressing tasks. The continuum of skills related to dressing in the mentally retarded population includes being passively dressed, accommodating the body to dressing, assisting in dressing and undressing, putting on and taking off clothes with supervision, independent dressing and undressing, daily selection and care of clothing, and purchase of clothing.

In order to learn self-dressing, residents must have an opportunity to wear a variety of clothing items, and not just clothing appropriate for sleeping. Moreover, they should be dressed appropriately to their level of ambulation and self-care. Clothing should be provided which minimally restricts proper body movement. Diapers are particularly detrimental in this respect, and should not be worn longer than is absolutely necessary. This means, of course, that residents should be involved in a systematic and intensive toilet training program.

Training in basic dressing skills should be conducted on a one-to-one basis. Direct care staff should relate to the resident in a warm and relaxed manner, and training in dressing should proceed at a leisurely pace. Initially, residents should be taught to extend their arms and otherwise accommodate the dresser. Even though residents may not yet be capable of verbal communication, direct care personnel should tell residents the names of clothing items and explain the dressing process as it occurs. In teaching the dressing process, dolls which can be dressed and undressed are a helpful aid in making children more aware of clothing and the dressing process.

Yes	No	
☐	☐	**Are residents allowed to wear a variety of clothing?**
☐	☐	**Is clothing appropriate to the resident's level of ambulation and self-care?**
☐	☐	**Are residents involved in a toilet training program which will later permit them to wear clothing other than diapers?**
☐	☐	**Are dressing activities conducted on an individual basis?**

☐ ☐ **Do direct care staff relate to residents in a warm manner and dress them at a leisurely rate?**

☐ ☐ **Do direct care staff tell residents the name of clothing items and explain the dressing process?**

☐ ☐ **Are teaching aids (e.g., dolls) used to facilitate training?**

As coordinated hand use and trunk control develop, residents can be urged to finish removing clothing items and to progressively assume more responsibility for a given item as their skill increases. Learning to undress usually precedes learning to dress. Thus, initially residents should be encouraged to finish removing socks from their feet, loose fitting pullover type shirts over their forearm and hands, and loose fitting shorts or trousers over the feet. When young residents begin to actively participate in the process of undressing, brief daily sessions in addition to regular dressing periods should be scheduled to teach specific movements associated with undressing and dressing. Residents should progress from completing a task such as removing a pullover shirt over the hands to removing it from over the arms and hands. Later, the task can be made more difficult by requiring the shirt to be removed over part of the head, the arms, and hands. Breaking tasks down in such a "reverse" order and gradually adding more difficult steps can also be applied to other clothing articles such as shorts or trousers, socks, and underwear. It is important that such training occur in a setting which is pleasant and distraction-free. Moreover, training should occur on an individual basis until communication and behavior control have developed to the extent that small group experience is possible. Clothing used in training sessions should be of the same type as clothing worn by residents during the majority of the day.

Obviously, clothing worn by residents during the period of basic dressing training should be subject to easy manipulation. Clothing articles such as shorts or trousers with elastic bands, loose-fitting pullover-type shirts, and slip-on shoes should be used initially. More difficult clothing having buttons, zippers, and snaps should not be used until residents have attained proficiency in manipulating simple clothing. It is, however, helpful to use practice boards which have over-sized buttons, zippers, snaps, or laces as aids in preparing residents for later achievements.

Yes No

☐ ☐ **Are residents encouraged to assume increasing responsibility in dressing and undressing?**

☐ ☐ **Is supplementary training provided to teach specific movements?**

☐ ☐ Are systematic techniques used in dressing training activities?

☐ ☐ Are residents removed to an area which is free of distraction?

☐ ☐ Are residents trained on an individual basis?

☐ ☐ Are clothing items used in special training sessions the same as those worn during the day?

☐ ☐ Are clothing items easily manipulated?

☐ ☐ Are teaching aids (e.g., practice boards) used in the training program?

Special training activities concerned with undressing and dressing should continue until residents can independently dress and undress with simple clothing (e.g., pullover shirts, trousers with elastic bands, stretch-type socks, underwear, and slip-on shoes) without specific instruction, either gestural or verbal, during the process of dressing. It is most important that residents be allowed to exercise the same degree of independence during routine daily dressing as during special dressing training sessions.

As residents gain proficiency in dressing and undressing with simple clothing items, more difficult clothing items having buttons, zippers, and snaps should be gradually introduced. Special teaching aids such as practice boards should still be made available to residents having difficulty with more complex clothing. Most residents at this stage can be taught new dressing skills as a part of the daily routine of dressing. In addition to clothing details such as buttoning, lacing, and tying, residents should be specifically instructed regarding "front and back" and "inside and outside".

Yes No

☐ ☐ Are residents progressively encouraged to complete more of dressing tasks until independence is achieved?

☐ ☐ Are consistent training techniques used in both regular and special dressing periods?

Is the complexity of clothing worn by residents increased in relation to individual levels of dressing proficiency?

☐ ☐ Are special teaching aids still available to those residents who are having trouble dressing with more difficult clothing?

☐ ☐ Are residents taught new dressing skills (e.g., front and back)?

Although choices in wearing appropriate alternative clothing items should be afforded residents during the initial stages of dressing training, the focus of training should gradually shift to teaching residents to select clothing items which are appropriate for weather, seasonal, and climatic conditions. Clothing must thus be stored in a convenient manner which allows residents to make increasingly independent selections. This means that clothes should be stored on shelves or racks which are easily accessible and within the resident's reach. Residents should be allowed to wear clothing which reflects normal dressing patterns in the home and community. Many institutions have established dressing codes for their residents which are so different from community standards that the mentally retarded become highly conspicuous in the community. This has been particularly common in the case of female residents, who have often been required to wear unfashionable clothing (e.g., unusually long skirts) in the interest of "modesty".

Yes	No	
☐	☐	Are residents allowed to participate daily in the selection of clothes to be worn?
☐	☐	Are clothes stored so as to enable selection by residents?
☐	☐	Are residents taught to select clothing which is appropriate to weather, season and climate?
☐	☐	Are residents permitted to wear clothing which conforms to current styles?

Residents should also begin to become involved in the selection and purchasing of clothing by accompanying volunteers and staff on trips to the community. At first, training should focus on appropriate social behaviors during the buying process (e.g., identifying clothing stores and clothing departments, requesting assistance, paying for items). Later, actual participation in the selection of clothing items should be encouraged. (Although typically denied the opportunity, even the profoundly retarded are capable of making simple choices among clothing items.) Residents should gradually be given increasing responsibility for selecting and purchasing clothing items. Residents should be trained to discriminate among clothing of varying qualities in terms of such criteria as quality of material and workmanship and style. The availability of catalogues and magazines which include sections of men's and women's fashions are most helpful. Residents should also be taught to compare prices among similar items of clothing and to recognize

a true bargain from a false one. As soon as appropriate buying habits have been established, residents should be allowed to make independent shopping trips in the community.

Yes	No	
☐	☐	**Are residents allowed to accompany volunteers or staff when clothing items are purchased in the community?**
☐	☐	**Are residents progressively prepared for independent selection and purchasing of clothing?**
☐	☐	**Do residents receive instruction regarding clothing quality?**
☐	☐	**Are residents taught to compare prices?**
☐	☐	**Are residents permitted to shop independently once appropriate buying habits have been demonstrated?**

Residents should have their own personal areas for their belongings. They should be instructed in regard to hanging and folding clothing for storage in closets and drawers while not in use. Training should also encompass proper care of clothes, including mending, laundering, and ironing. This means that necessary materials and appliances (e.g., sewing machines, irons, washers and dryers) must be available on the living unit and residents must be trained in their use.

Yes	No	
☐	☐	**Do residents have personal storage areas?**
☐	☐	**Are residents taught to fold or hang clothing items?**
☐	☐	**Is there a program for teaching residents clothing repair and care?**
☐	☐	**Are basic home appliances available to residents?**

TOILET TRAINING

Training in toilet use usually progresses from incontinence to passively being placed on toilet at logical times . . . from toilet regulating and discriminating between being wet and dry to indicating by gesture or other means a need to eliminate . . . from assisted toilet use to removing clothing with decreasing assistance . . . and, finally, from going to toilet as needed to independently wiping, flushing the toilet, and washing hands. Mentally retarded persons should be encouraged to progress as far along this continuum of skills as possible.

During a resident's initial uncontrollable period, diapers should be changed when wet or soiled rather than by a predetermined schedule, at specific intervals. Frequent changing is necessary in order to teach residents that being dry or unsoiled is different from being wet or soiled, and that the former is a more natural and pleasant state. Teaching a child to desire dryness is the first step in the toilet process. Each direct care person should be assigned the responsibility for observing a specific group of residents and ensuring that their diapers are changed as soon as they are wet or soiled.

Yes	No	
☐	☐	**Is there a consistent program to teach residents that dryness is a desirable state?**
☐	☐	**Are residents assigned to certain direct care staff so that responsibility for changing diapers can be established?**

When residents attain sitting balance, systematic attempts to toilet regulate them are appropriate. At first, it may be desirable to place residents on the toilet after they have soiled themselves in order to establish a relationship between elimination and toilet facilities. Prior to attempts to toilet regulate residents, individual daily charts should be kept showing frequency of elimination. In this way, residents can be taken to the toilet when there is the greatest probability of need. It is also helpful to place residents on the toilet before and after sleeping, after meals, and after periods of physical activity. In order to implement an effective toilet training program, an adequate number of toilets must be available to meet resident needs.

In all phases of toilet training, toileting facilities must be adapted to the physical requirements of the residents in order to facilitate training. For example, toilets should be at a height that makes it easy for residents to get on or off the toilet. Toilet seats should also be of a size that will not require residents to balance themselves on the rim of the toilet and will prevent residents from slipping into the toilet bowl. If some residents are smaller than

existing toileting facilities, properly adapted potty chairs should be readily accessible.

Yes	No	
☐	☐	**Is the individual resident placed on the toilet according to records which indicate when he generally eliminates?**
☐	☐	**Are an adequate number of toilets available?**
☐	☐	**Are toilet facilities appropriate to the physical size and needs of the residents?**

As passive regulation is established, direct care personnel should watch for and encourage residents to indicate a need to use the toilet. This means that residents must be supervised well enough to ensure that indications are detected prior to soiling or wetting. Direct care staff should verbalize the action of going to the toilet area each time toileting is attempted in an effort to help the resident associate these verbalizations with toilet use. Residents should be encouraged to exercise increasing independence in moving toward the toilet area, lowering and raising clothing, and flushing the toilet. Residents will gradually be able to independently direct themselves to the toilet area and require decreasing assistance. Toilet areas should, of course, be located in an area of the building which is easily accessible to residents.

Yes	No	
☐	☐	**Do staff watch for and respond to signs that residents are ready to use the toilet?**
☐	☐	**Do staff help the resident to associate appropriate verbalizations with toileting?**
☐	☐	**Are residents encouraged to develop increasing independence in toileting?**
☐	☐	**Are toilet facilities easily accessible to residents?**

Once residents attain independence in going to the toilet, training should focus on adequate wiping, flushing the toilet, and washing hands in the proper sequence. In this regard, it is necessary that toilet facilities be home-like, in the sense that tissue dispensers are easily accessible, toilets can be operated by residents, and towels and soap are available.

Provisions for privacy should be made as residents increase in independence. Even older residential institutions with mass toileting facilities can provide privacy for their residents by using various types of partitions or curtains in the toileting area. Once toilet training has been accomplished, residents should be afforded **full privacy** when using the toilet.

Independence in toileting should be enhanced by training residents to use the variety of toileting facilities they will encounter in the community. They should also be taught to discriminate between toilets designated as men's or women's and to behave appropriately in a public restroom.

Yes	No	
☐	☐	**Are residents taught the sequence of wiping, flushing the toilet and washing their hands?**
☐	☐	**Are toilet facilities sufficiently home-like to permit such training?**
☐	☐	**Is privacy provided residents in the toilet area?**
☐	☐	**Are residents instructed in the use of community toileting facilities?**

BATHING

The development of bathing skills generally progresses from being passively bathed to handling soap and washcloth; drying self to washing easy to reach body parts; complete bathing and drying with supervision to independent bathing and drying. Mentally retarded residents should be trained to progress as far as possible along this continuum of bathing skills.

During the passive bathing stage, bathing can be a highly pleasurable experience which helps maximize individual contact and interpersonal responsiveness. It is a time when the resident can be talked with, sung to, and handled gently and affectionately. Unfortunately, bathing in many institutions is a highly mechanized "assembly line" affair. For example, one person may undress the resident, another apply soap, and still another rinse. This practice prevents bathing skills from developing and constitutes an impersonal and dehumanizing bathing technique.

Initially, bathing should occur on an individual basis wherein residents can learn to handle soap and a washcloth, even though it may be in only a playful manner. Direct care staff should be assigned responsibility for bathing specific residents each day. This will enable the establishment of a sound interpersonal relationship between the resident and the person responsible for his daily bathing. In addition, the staff member will be able to gauge the resident's progress and respond in a meaningful manner to his individual training needs.

Bathing facilities should be appropriate to the size and physical requirements of the resident. Thus, infants should not be bathed in full size tubs. When showers are used, the shower head should be at an appropriate level in relation to the resident's height. Bathing facilities should not be so designed as to make training in self bathing difficult for direct care staff to conduct. Thus, a large shower room designed for mass showering would result in direct care staff becoming soaked if they attempted to actively assist and train the resident. Gradual encouragement should be afforded to help the resident progress from playful handling of a washcloth to actually applying a washcloth to parts of the body. By guiding the hand movement of a child with a washcloth, basic bathing patterns can be established. Residents can be taught to partially dry themselves as they are learning to assist in bathing. Learning to properly handle a towel should be encouraged by directing necessary movements both verbally and gesturally. Residents should also be encouraged to independently dry at times when the face or hands are washed. Residents should be given increasing responsibility for drying themselves as their proficiency increases.

Yes ☐ No ☐ **Do direct care staff interact with residents and attempt to make bathing a pleasurable and desirable experience?**

Yes	No	
☐	☐	Are residents taken individually to the bathing area and afforded individual attention during the bathing process?
☐	☐	Is there consistency regarding personnel who bathe certain residents?
☐	☐	Are bathing facilities appropriate to the size and physical requirements of the resident?
☐	☐	Are residents allowed to handle the towel?
☐	☐	Are residents encouraged to participate in drying?
☐	☐	Are residents progressively encouraged to dry more of the body area?

Bathing should progress to resident's participating in the bathing process by washing easy-to-reach body parts such as the arms and hands, abdomen, and legs. There should, however, be progressive encouragement to thoroughly wash more of the body area as coordination and balance develop. Soap should be in bar form so that it can be easily handled and applied by residents.

Assistance in the bathing process should be gradually diminished to the extent that residents can perform bathing with only perfunctory supervision. Individual supervision should be continued to ensure the development of more thorough bathing habits. Special attention should be focused on thorough washing, rinsing and drying of hair, ears, neck, genitalia, and feet. Supervision in bathing and drying should be afforded individual residents until thorough bathing and drying of the entire body area are consistently accomplished.

Yes	No	
☐	☐	Is there consistent encouragement for residents to bathe more independently?
☐	☐	Is soap in bar form so that residents can easily handle and apply it?
☐	☐	Is there specific instruction regarding the thorough washing of various body parts?
☐	☐	Is supervision provided until the resident has demonstrated his mastery of washing and drying?

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As residents are increasing their proficiency in bathing, they should also learn related skills. They should be taught proper methods of regulating water temperature for a tub bath or shower and appropriate water levels for tub baths. Requirements for cleaning tub or shower after use should also be taught. Safety measures relative to entering or leaving bath tubs should be practiced.

Residents achieving an independent status in bathing should be afforded and encouraged to use provisions for privacy while bathing. The program structuring which was initially required for individual supervision should yield to flexible bathing times, so residents can bathe in relation to need or daily activities. Programming at this stage should focus on individual care and storage of toilet articles, the cleanliness and neatness of bathing area, and the handling of used towels, washcloths and clothing articles.

Yes	No	
☐	☐	**Does the design of the bathing facility permit the learning of water temperature control?**
☐	☐	**Are residents instructed in the cleaning of bathing facilities?**
☐	☐	**Are residents instructed as to necessary precautions regarding entering and leaving bathing facilities?**
☐	☐	**Are residents afforded at least partial privacy while bathing?**
☐	☐	**Are bathing practices structured around activities which necessitate bathing, rather than by a fixed schedule?**

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COMMUNICATION

Communication constitutes both verbal and non-verbal exchanging of ideas or information. Facial expressions and gestures are forms of non-verbal communication, while words are a form of verbal communication. The continuum of communication behaviors in the mentally retarded population may range from the primary level of crying to more advanced levels such as reading, writing, and use of the telephone.

The voice of a familiar person may be the first and most important sound to which the young child learns to listen. The awareness of voices should be reinforced immediately with smiles, caresses, and attention. It is also important that the resident's living environment contains pleasurable sounds and noises. An environment characterized by constant and aversive noise (e.g., screaming) seriously interferes with the individual's ability to discriminate specific sounds and words, and prevents the development of language skills. The periodic "healthy noise" of children is desirable, but there should also be periods of quiet activity when words can be heard dstinctly. Activities such as singing to residents, imitating animal noises and telling stories can form the basis for enjoyable interpersonal relationships which make residents increasingly receptive to communication.

Yes	No	
☐	☐	**Do staff reinforce attention to voices through smiles, caresses, and attention?**
☐	☐	**Does the living unit contain a variety of pleasurable sounds?**
☐	☐	**Are periods of quiet activity provided?**
☐	☐	**Do staff provide varying verbal stimulation to residents (e.g., singing)?**

As residents begin to listen to sounds and words — and even before they begin to use words as a form of communication — they can learn to listen and respond to spoken words. At this stage, training can focus on teaching residents to appropriately respond to their name, and simple commands such as "come", "sit", and "stand". Direct care staff should initially show residents the purpose of speech by teaching them to point to objects, pictures, and body parts that are named. Later, residents will begin pointing in order to ask the names of objects. Residents can also be taught to bring the living unit staff simple objects in response to verbal or gestural instruction.

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The development of language should be stressed in all areas of training (e.g., eating, dressing, toileting, and bathing). In order to develop communication skills, persons working with residents must listen and respond appropriately to residents' attempts to communicate. Residents should also be required to express their needs either verbally or non-verbally. Although appropriate responses to verbal and gestural instruction will be learned in other training activities, residents should be introduced to special language development sessions on a daily basis during the pre-speech period. The duration of language sessions should be brief at first, lasting 10-15 minutes per resident, and be progressively extended to perhaps 30 minutes as the resident's attention span increases.

It is imperative that direct care staff utilize a standard vocabulary of words and gestures so that residents will receive consistent sounds and signals in relation to desired actions and will avoid becoming confused. A standardized vocabulary should be written or recorded in such a way that it can be used systematically by direct care staff who work with specific residents. The words used with an individual resident should be appropriate to his level of language development. So-called "baby talk" (e.g., words such as "footsie", "goodums", etc.) should be avoided. The purpose of a standardized vocabulary is to assist in the development of communication, self-help, and social skills. The standardized list should thus be periodically evaluated in terms of its effectiveness in assisting residents to attain increased competency in these areas, with modifications being made as needed. To ensure consistency of words used, direct care staff should discuss language progress daily during change-of-shift meetings. The necessity of a consistently used standardized list of words becomes obvious when one considers the variety of words that could be used to refer only to the toilet (e.g., "john", "head", "pot", "commode", "seat", etc.).

Yes	No	
☐	☐	**Are residents taught to respond to simple words and commands?**
☐	☐	**Are residents encouraged to communicate their needs?**
☐	☐	**Do staff listen to residents when they attempt to communicate?**
☐	☐	**Are daily language development sessions provided for all residents?**
☐	☐	**Is a standard list of words available to facilitate resident training?**

Yes	No	
☐	☐	**Is such a list applied on an individual basis so as to be appropriate to each resident's level of language development?**
☐	☐	**Is the list frequently evaluated and updated?**
☐	☐	**Is consistent use of words maintained between shifts by frequent inter-shift discussions?**

Once speech has begun to emerge, language development should progress from learning to recognize and name body parts and objects to the use of descriptive words such as "big", "small", and action words such as "run", "skip", and "jump". The learning of many action words can be facilitated by music games wherein actions are associated with words. Picture books, magazines, story sessions, and table games requiring basic communication can also be used to effectively introduce size and directional concepts. Residents should also be taught to express their sensations when using senses such as sight, hearing, smelling, tasting, and feeling. Another important activity is recognition of similarities and differences in objects.

Special materials and techniques such as hand or finger puppets, music games, story sessions, simple nursery rhymes, songs, and scrapbooks containing pictures residents have learned to name should be used by direct care staff to encourage listening and speaking skills. Games should also be introduced which require taking turns and giving action responses to verbal instructions, thereby teaching the residents to respond appropriately in a group setting. The difficulty level of training materials and activities should be progressively increased as residents achieve increased language proficiency. Special speech exercises and other techniques are available to help residents learn sounds which are difficult to learn and enunciate. In this regard, language development specialists can offer valuable assistance through consultation, inservice training, and individual help in unusual cases.

Yes	No	
☐	☐	**Are residents taught descriptive and action words?**
☐	☐	**Are residents taught size and directional concepts?**
☐	☐	**Are residents taught to discriminate similarities and differences?**

Yes	No	
☐	☐	**Are a variety of special materials and techniques used to develop listening and speaking skills?**
☐	☐	**Are materials and activities progressively changed as residents increase in language proficiency?**
☐	☐	**Are residents taught to appropriately respond in group social settings?**
☐	☐	**Are language development specialists available to offer assistance to, consultation with, and training of direct care staff?**

Language development should proceed from the use of descriptive and action words and basic concepts to more complex word concepts which might include "over", "under", "beside", and "near", and "far". Residents should be specifically helped with the use of plurals, word combinations, and pronouns such as "I" and "you". They need to learn to listen when others speak and be allowed opportunities to talk with adults.

The acquisition of other concepts and skills can be incorporated in language development activities. For example, time concepts such as "yesterday", "today", and "tomorrow" can be taught along with an explanation of what will happen to residents during given time periods.

Preparation for counting and reading can also occur in language development activities. Counting skill can be introduced by having residents count items such as cookies that are to be eaten. They can be made aware of the alphabet through the use of cut-out letters which are made of sandpaper or textured materials, by walking or crawling over letters painted on the floor, or by guided sand tracing.

Yes	No	
☐	☐	**Are residents introduced to pre-school or kindergarten type activities wherein they are taught word and time concepts and pronoun usage?**
☐	☐	**Are residents taught the use of numbers?**
☐	☐	**Are residents taught that letters are related to words?**

Communication programs should progressively focus on teaching residents to listen and to follow instructions, share their experiences orally with others, wait their turn in speaking, use proper voice volume and rate, ask and answer questions, and organize their

thoughts before speaking. Because of insufficient training, many mentally retarded residents are unable to engage in appropriate conversations with strangers. Such residents often attempt to focus the conversation upon topics which are of high interest value to them (e.g., a description of their pets or of some aspect of institutional life) but are extremely boring to strangers. Conversational skills, including proper listening habits, should thus be a continuing area of emphasis. Reading and writing skills are ordinarily developed within the context of the academic school program. Classroom learning should be reinforced on the living unit. This may be accomplished by having teachers assign homework which can be completed with the assistance of living unit staff. Other activities aimed at increasing communication skills might include group discussions of topics related to the academic school program (e.g., laws and rules in the community) and role play sessions which provide practice in communicating with others (e.g., asking a stranger in the community for directions). Such activities, of course, demand close coordination and ongoing communication between academic school and living unit personnel.

Communication skills such as reading, writing, and speaking should be encouraged by frequent opportunity for practical experiences. Residents should be trained to properly use telephones. Following such training they should be allowed to use the telephone independently. Residents should also be encourged to correspond to others by letter, and stay abreast of current events by reading magazines and newspapers. Moreover, residents should be allowed to visit community settings wherein they can learn proper communication in such areas as buying articles, ordering foods, asking directions, and use of public transportation.

Yes	No	
☐	☐	Are residents given training and practice in conversational skills?
☐	☐	Are communication skills learned in the classroom reinforced by living unit staff?
☐	☐	Are residents taught to use telephone?
☐	☐	Are they allowed to use telephone outside of training setting?
☐	☐	Are residents encouraged to correspond with others by letter?
☐	☐	Are residents afforded and encouraged to read newspapers and magazines?

THE ACADEMIC SCHOOL PROGRAM

It has been emphasized throughout these materials that all facets of residential programming should be educational in nature. That is, the full range of daily activities should be aimed at increasing: (1) complexity of behavior; (2) control over the environment; and, (3) socially designated "human" qualities. This section, however, will focus upon the traditional educational process which revolves around the formal academic school program. This process may be thought of in terms of three basic stages: (1) preschool training; (2) school experience; and, (3) adult education.

A major content area in the pre-school phase is sensori stimulation. Residents in a pre-school level program should be taught to listen and recognize sounds, recognize weight differences, touch various textured materials to determine surface differences, taste flavors, identify common odors and sort objects by color, size and shape. They may be taken on walks and encouraged to point out various objects which they encounter. Visual retention can be taught through games requiring recall of objects and missing parts. Music, songs and rhymes promote auditory memory and teach the resident to listen and respond appropriately. Playing store, dress-up and other games offers a further variety of opportunities for using all senses and teaches related language and social behavior.

A second major area is cognitive training. The resident should be helped to achieve orientation in time and place, and to make simple discriminations. Recognizing the similarities and differences in objects will be important to later learning. Concepts such as "over and under" and "near and far", "large and small", are also essential to facilitate training in other skill areas. Residents should also be taught other simple problem solving. They can learn to discriminate between large and small objects, search for hidden articles, sort according to size, shape or color and use cut-out puzzles. Making pictures by connecting outline dots is also a valuable learning experience. When provided, pre-school training has traditionally been limited to young mildly and moderately retarded residents. However, the content areas included in this phase should also be incorporated into the training schedules of older severely and profoundly retarded residents.

Yes	No	
☐	☐	**Is pre-school training provided for young mildly and moderately retarded residents?**
☐	☐	**Is such training included in the daily activity schedules of older severely and profoundly retarded residents?**

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During the school age years, mildly and moderately retarded residents should participate in a formal school program. The cur-

riculum for mildly retarded residents will cover subject matter up to a fourth or sixth grade level. In the case of the moderately retarded, emphasis will be placed upon practical living skills and rudimentary academics (e.g., basic number concepts and recognition of critical words). The residential facilities' curricula for mildly and moderately retarded should comply with state standards for community-based special education programs. This will not only help to ensure quality programming, but will facilitate the resident's entrance into a community program in the event that he is returned home or allowed to attend classes outside of the institution. Eligibility for participation in the formal academic program should not be inflexibly limited to residents classified as mildly and moderately retarded. In view of the error factor inherent in standardized intelligence tests and other evaluative techniques, a resident classified as severely retarded **may** possess the basic skills required for academic school placement.

Residents should not be excluded or expelled from school programs because of behavior problems or their inability to adapt to traditional curricula. As stated in NARC's **Policy Statements on the Education of Mentally Retarded Children** (NARC, 1971), "The responsibility for developing appropriate educational techniques and/or modifying disruptive classroom behavior patterns rests with the school system. Failure to adapt to traditional educational models should thus not be viewed as a legitimate basis for exclusion or expulsion. Failure to learn at a level commensurate with intellectual potential is not caused by something within the child, but rather, results from the use of inappropriate educational technologies."

Student mobility within the educational program (e.g., from the primary to the intermediate level) should be based upon clearly defined achievement criteria rather than age or length of time at a given level. In this regard, the NARC education policy statements state "Specific achievement outcomes must be spelled out for each level of retardation and for each component of the curriculum. A child should continue at his age level until these minimal outcomes or expectancies have been attained. If a child appears to be retained at a particular school level for an inordinate amount of time, the accuracy of his placement and/or the teacher's effectiveness and appropriateness of curriculum content must be re-evaluated."

Yes	No	
☐	☐	**Do academic school curricula comply with state guidelines?**
☐	☐	**Is eligibility for the academic school program flexible and not restricted solely to the mildly and moderately retarded?**

Yes ☐ No ☐ **Do school personnel assume responsibility for modifyng disruptive classroom behavior and developing educational techniques designed to overcome individual learning difficulties?**

☐ ☐ **Is mobility within the school program based upon the achievement of clearly defined criteria?**

In discussing educational rights of the mentally retarded in residential facilities, NARC has stated that "The public education agency charged with overseeing community education programs should have the responsibility for the education of mentally retarded persons who are in residential care settings. Teachers within these facilities should be certified in their field of competency according to the same criteria employed in public schools." Teachers should also meet at least the same personal and technical qualifications as their counterparts working with nonretarded pupils. With regard to class size, the NARC document states that "School policy regarding class size, composition, and teacher-pupil ratio should allow considerable flexibility in order to design the appropriate classroom setting for every retarded child. In general, class size could be increased as the age of the student increases. A guideline for teacher-pupil ratio in classes composed of mildly and moderately retarded students below 13 years of age should be no more than 10 students to one teacher; and, above 13 years of age the ratio might increase to 15 students to one teacher. Also, a chronological age span of not more than three years, and an instructional span of not more than three grade or achievement levels is recommended."

Yes ☐ No ☐ **Is the academic program under the public agency responsible for community school programs?**

☐ ☐ **Are teachers certified according to the same criteria as their counterparts in community schools?**

☐ ☐ **Are age and instructional spans within recommended limits?**

Curricula for the mentally retarded should not be a simplified version of curricula intended for young nonretarded students. Rather, the academic school program should be geared toward the practical aspects of daily living and toward equipping the resident to leave the facility and to become effectively integrated into the community. Practical considerations should be introduced early in

the curriculum. Thus, simple counting can be taught using common objects in their environment which have practical significance to residents. Fractional parts can be introduced using food or money. In the latter regard, the resident should be taught to recognize money denominations and make change. This means, of course, that residents must be allowed to carry and use real money rather than being limited to tokens or some type of script. Understanding the meaning of day and night; yesterday, today and tomorrow; and days of the week or months of the year should precede learning to tell time. Practical measurement concepts and procedures should also be introduced early in the school curriculum. The main objective of programs in basic reading and arithmetic for moderately retarded residents is to provide useful skills which will enable them to move about their environment as safely and independently as possible. They must be able to read traffic and informational signs, labels on packaged articles, phone numbers and addresses and to recognize the names of frequently encountered objects in their environment. Examples of other critical curricula items might include being careful when crossing streets, being aware of moving traffic, learning to use swinging doors, stairs, elevators and escalators, recognizing the meaning of sirens, warning lights and danger signs and proper regard for fire, hot liquids, and electrical appliances. The proper use of potentially dangerous objects such as knives, electrical appliances, and scissors should be taught, and residents should have practical experience in handling substances which may be poisonous or otherwise dangerous. The safe use of public transportation vehicles is another skill to be learned. The effective use of leisure time via generic community and social outlets is also critical. The development of vocational skills is essential. These skills should be emphasized early in the curriculum and should be integrated into learning activities throughout the school phase.

Teaching materials should be appropriate to the chronological or social age of the student. For example, a mildly retarded adolescent will quickly lose interest in reading taught with books aimed at nonretarded eight year olds. Age-appropriate materials can, however, be readily obtained (e.g., a text at the third grade reading level which deals with such teenage interests as hot rods and social activities). Innovative approaches to classroom instruction (e.g., team teaching and programmed instruction) should be employed.

Heterosexual relations and marriage are not frequently presented as a natural way of life for residents of large, publicly supported residential facilities. The tendency toward overprotection in this regard poorly equips residents for the examples of sexual behavior they will encounter in the community. Although the actual incidence of marriage among mentally retarded persons is not presently known, most mildly retarded persons apparently do marry and have children. It is, therefore, essential that school programs reflect a natural acceptance of sexuality as a valid part of residents' lives

which must be dealt with frankly and openly. The sexual components of growth and development can be easily incorporated into other curriculum areas, with special instruction provided in regard to aspects of heterosexual behavior such as birth control and the responsibilities of marriage and parenthood.

Yes	No	
☐	☐	**Do curricula emphasize practical aspects of daily living (e.g., handling money, simple measuring procedures, etc.)?**
☐	☐	**Are residents trained in the basics of personal safety (e.g., traffic safety and the handling of potentially dangerous materials)?**
☐	☐	**Are vocational skills stressed throughout the school curriculum?**
☐	☐	**Are teaching materials appropriate to chronological age and social interests?**
☐	☐	**Are innovative teaching approaches utilized? Is sex education a part of the school curriculum?**

The formal education program should provide for the continuing education of adult residents who have completed the basic school curriculum. Educational curricula for adult residents should represent an extension into adulthood of previous school programs, with particular emphasis upon the practical details and responsibilities of independent community living. Examples of the types of practical information which should be taught might include how to complete a job application, job interview behavior, learning to drive, how to find a place to live, budgeting, banking money and writing checks, purchasing food and clothing, what to do when ill, and filling out income tax forms. Further instruction in the laws and rules of the community will be needed periodically, and the basics of personal safety must be frequently stressed. Some residents will also require special training in regard to personal appearance and hygiene. The importance of good nutrition, exercise and a productive use of leisure time can be taught in relation to routine activities of daily life and recreation in the community.

Yes	No	
☐	☐	**Is a formal program of adult education provided?**
☐	☐	**Does the curriculum focus upon areas relevant to daily living in the community?**

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The formal academic program should be closely coordinated with living unit learning activities. Skills taught in the classroom may thus be reinforced by living unit personnel. Unit teams should include members of the school faculty who work with the unit's residents. In addition to team meetings, academic school personnel should meet with the living unit staff on a frequent and regularly scheduled basis to ensure that learning goals and techniques in the two situations are compatible and mutually reinforcing. For students not enrolled in the formal school program, academic school faculties should meet regularly with living unit staff to assist them in developing appropriate training programs. While homework is traditionally not assigned to mentally retarded people, this practice cannot be justified by current knowledge of the learning process. Students enrolled in the formal education program should thus be assigned homework and assisted in this area by living unit staff in order to compensate for deficiencies in learning or to accelerate progress. When special education classes are available in the surrounding area, the residential facility should aggressively seek to ensure that residents are educated in community schools.

Yes	No	
☐	☐	**Is the school program coordinated with living unit learning activities?**
☐	☐	**Do school personnel meet regularly with living unit personnel to assist them in developing training programs for students not enrolled in the formal academic program?**
☐	☐	**Is homework sometimes assigned to academic school students?**
☐	☐	**Do residents attend special education classes in the community?**
☐	☐	**If not, is the residential facility aggressively pushing for their inclusion in such programs?**
☐	☐	**Do pre-school level programs include systematic training in sensori stimulation and cognitive development?**

WORK TRAINING

Society generally expects all post-school age persons to work. Traditionally, the more retarded residents of institutions have been denied the opportunity to participate in meaningful job-related activities. However, even profoundly retarded adults are currently participating in work activity center programs in some areas of the United States. Although the goal is not to produce competitive workers in the traditional sense, the profoundly retarded can be actively engaged on a daily basis in projects that help prevent unnecessary physical and psychological deterioration and enhance their acceptance in the nonretarded world. All mentally retarded persons should be provided with the opportunity to move as far as possible along the continuum of work-related behaviors.

Many retarded persons enter competitive or noncompetitive employment situations with serious work deficiencies. They do not understand the meaning of work or the day-to-day responsibilities required on the job. Basic work training involves training in work habits, work skills, and attitudes toward work. As soon as basic self-help skills have been developed, residents should be given increasing responsibility for keeping their living areas neat and clean. Training should be given in such basic areas as listening to and following simple instructions and commands, remaining at a productive task for increasingly longer periods of time, and interacting in an appropriate manner with other residents and staff.

Yes	No	
☐	☐	**Are residents given increasing responsibility for living unit tasks?**
☐	☐	**Do dormitory programs include training in basic work-related habits, skills and attitudes?**

Since competitive employment is currently believed unattainable by the more severely retarded, work activity programs have been established in some sections of the country. The types of skills which are taught in these activity centers include sorting, transferring, inserting, pulling, wrapping, sealing, and folding. Even the operation of industrial machinery has been accomplished by profoundly retarded workers when the task consisted of pulling levers or otherwise activating machinery at scheduled intervals. Such innovative ways of utilizing the profoundly retarded in work activities strongly suggest that their alleged paucity of skills may only be valid in a world designed exclusively for nonretarded workers.

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Activity centers differ from sheltered workshops in that activity programs incorporate the simplest skills of adult living including grooming, housework chores, leisure time activities, and appropriate use of community facilities. Although purposeful work is an essential component of the center programs, production is not a

primary goal. Such work activities, however, promote positive concepts of self and society which are fundamental to normalization and social acceptance. Work activity programs may be housed in the community or on the grounds of the residential facility. They should not, however, be located in the same building in which the participants live. This separation between living and work areas is emphasized in the accreditation standards.

Yes No

☐ ☐ **Are profoundly and severely retarded residents given the opportunity to participate in work activity programs?**

☐ ☐ **Are work activity programs housed separately from the residents' living area?**

☐ ☐ **Are grooming, self-direction, and purposeful use of leisure time part of activity center programs?**

Sheltered workshops further the vocational habilitation of mentally retarded residents through several types of remunerative work intended to prepare adult residents for later placement in private industry, or to provide continuing employment for those unable to successfully compete in the open labor market. Some workshops obtain voluntary contributions of used objects which are made re-salable through cleaning, painting or repairing. Proceeds from the sale of such items are used to pay the workers. Other workshops are supported by private firms or governmental agencies through sub-contracts. Such work is usually separated into sub-assemblies in order to reduce the jobs to their most elemental parts, and remuneration is based on quantity of unit production. Although bench work and assembly contracts account for a major portion of the work performed in sheltered workshops, retarded workers are by no means limited to these jobs exclusively. There have been workshops involved in the operation of gas stations and printing shops, agricultural and livestock enterprises as well as refinishing, repairing, packaging, and other manufacture-related activities. All residents participating in a sheltered workshop program should receive some pay, regardless of their level of productivity. The amount which the resident is paid should be determined by the quantity and quality of his work.

Yes No

☐ ☐ **Does the sheltered workshop provide job training for placement in private industry as well as offer continuing employment for retarded persons who cannot compete in the open job market?**

Yes No

☐ ☐ **Do all workers receive some pay?**

☐ ☐ **Are pay schedules based upon quantity and quality of work?**

In addition to production, workshop programs should provide occupational services including screening applicants, occupational evaluation, personal adjustment training, selective job placement, and follow up. The physical location of a workshop may directly influence the overall program orientation. For example, if a workshop is operated in conjunction with a school or residential program and identifies closely with the activities of the facility, it will be difficult to establish and maintain a realistic work-oriented environment. In most cases, therefore, it is preferable to locate the workshop within the business and industrial community. In this regard, residential institutions and other agencies have successfully operated workshop programs within established workshops such as Goodwill Industries of America or the Jewish Vocational Service. At times it is possible to incorporate programs for the retarded within existing rehabilitation programs designed originally for the physically handicapped. The potential advantages of this approach include the possibility of utilizing supportive occupational services (e.g., occupational evaluation) which the parent workshop is already providing for its present clients.

Yes No

☐ ☐ **Are work-related services such as evaluation and work adjustment training provided in addition to remunerative work opportunities?**

☐ ☐ **Is the workshop physically located within the business and industrial community?**

Beginning in early adolescence, mildly retarded residents should receive a series of pre-vocational evaluations in a variety of job areas to determine potential vocational interests and aptitudes. This involves providing the resident with the opportunity to actually experience a number of work areas for relatively brief periods (e.g., a series of two-week sample placements). The time allowed, however, should be adequate to obtain a fair assessment of the resident's interests in and aptitude for the areas sampled. The assessments should be conducted by personnel who are trained and experienced in the areas of vocational rehabilitation and job evaluations. Information derived from these evaluations can be combined with data obtained later when residents begin work-study programs. The types of jobs considered during the pre-

vocational evaluation should be comparable to the jobs actually available in the community where the resident will be eventually placed. Too often, residents are evaluated for jobs which are characteristic of a large residential institution (i.e., laundry, maintenance, and janitorial) but have little relevance to community placement. At the same time, some institutional job areas are beneficial in establishing basic work habits such as being on time, responding appropriately to supervision, and continuing an assigned task to its completion. Non-paid institutional job assignments, however, should serve only to teach residents proper work habits and not to fill regularly paid personnel positions. Trial job assignments should thus be directly related to specific objectives which have been established for the resident in the area of vocational training, and time limits should be established. Some residents who, according to current evaluations, appear to be incapable of competitive employment in the community, may be assigned institutional jobs on a semi-permanent basis in lieu of work activity center or sheltered workshop placement. All of these residents should be paid. The amount of pay should be dependent upon the work performed, using the pay scale for institutional staff performing comparable jobs as the baseline figure (i.e., if it is determined by objective work samples that the resident produces at a third of the rate of a staff member receiving $300 per month, the resident should be paid $100 per month).

Yes	No	
☐	☐	**Are a variety of optional job areas considered in the pre-vocational evaluation phase?**
☐	☐	**Is adequate time allowed for each pre-vocational job sample to obtain a fair assessment of resident's interests and aptitude?**
☐	☐	**Are evaluations conducted by qualified personnel?**
☐	☐	**Are proposed job areas available in the community?**
☐	☐	**Are non-paid institutional job assignments used only for temporary training purposes?**
☐	☐	**Are residents paid for semi-permanent institutional work assignments on the same basis as staff holding comparable positions?**

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Following pre-vocational evaluation, the school curricula should incorporate part-time vocational training and work experiences

within the resident's daily scheduled activities. Most work-study programs are designed to facilitate successful transition from school to employment. Residents may spend part-time in learning specific job skills and part-time in school. Other work-study programs alternate periods of full-time work and full-time school attendance. Since work-study programs are a precursor to actual job placement, a variety of options for work areas should be available. These options should be realistic in terms of the job market in the community where the resident will ultimately work (e.g., a resident who will likely return to a rural area should not be trained in urban-oriented job areas).

As the resident approaches adulthood, it becomes increasingly important that school and vocational curricula are closely integrated with training in other independent living skills. When school subjects begin focusing to a greater degree upon specific work and independent living skills such as housekeeping, money management, and budgeting, corresponding changes should occur at the living unit level. Residents, for example, can be "paid" in tokens for school attendance, work, and housekeeping. The "money" earned is then used to pay for rent, utilities, food, and other needed items such as toothpaste, deodorants, shaving cream, shampoo, hair dressing, etc. Some special events or items such as trips, records, magazines, and personal radios may require saving or budgeting. Such an approach can be used to make the institutional setting more community-like, thereby facilitating the transfer of learning from the institution to the community.

Yes	No	
☐	☐	**Is there a systematic work-study program?**
☐	☐	**Are a variety of job options made available to residents before final vocational placement?**
☐	☐	**Are job options realistic regarding the community job market?**
☐	☐	**Is vocational training integrated with the school curricula?**
☐	☐	**Is there a progressive emphasis on independent living skills and vocational skills which will help prepare residents to live and work in the community?**

Primary responsibility for the vocational counseling and placement of institutional residents in competitive community employ-

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ment is usually assigned to counselors associated with the state offices of the vocational rehabilitation administration. It is the responsibility of the vocational counselor to determine whether a resident is ready for placement, make appropriate arrangements with the employer, and guide the resident throughout his job trial period. Services provided by these counselors include individual medical, psychological, social and vocational evaluations, vocational training, job placement, funds for prosthetic appliances, transportation, and on-the-job training, selective placement and follow up and individual vocational counseling throughout the process. There is usually follow up on each placement by the vocational counselor lasting for approximately three to six months.

Yes	No	
☐	☐	**Are trained vocational counselors available to assist in community job placement?**
☐	☐	**Are funds available to the counselor for needed supportive services (e.g., transportation and prosthetic devices)?**
☐	☐	**Are provisions made for adequate follow up following community job placement?**

COMMUNITY LIVING

A frequently debated issue in residential facilities is the question of whether all retarded residents should be programmed for community adjustment. If it should be found desirable to program differentially for institutional residents, depending on whether they are to remain in the institution or be returned to the community, it becomes important to decide at what point in the resident's life a decision should be reached regarding his future, and on what basis. Perhaps the most feasible and "humane" approach at our current stage of knowledge would be to assume that all retarded persons have the potential for discharge from the institution until their response to programs aimed at discharge (appropriate and intensive programs and trial placements in a variety of community settings) clearly reveals the inappropriateness of this goal, or unless the prognosis — based on a thorough evaluation — obviously indicates lifetime institutionalization will be necessary (as in advanced cases of progressive neurological deterioration or gross neurological pathology, such as anencephaly). In most current institutions, this decision is either never made or, when made, if it appears currently unfeasible to return the resident to the community, he is relegated to a "custodial" program.

Yes	No	
☐	☐	**Is returning residents to the community the primary goal of the institution?**
☐	☐	**Does the institution have a procedure for evaluating individual resident's potential for community return based upon his response to training programs and trial placements?**

Residential institutions should have a clearly established plan for moving residents into the community. It has been demonstrated that persons at all levels of retardation, including the profoundly retarded, can successfully live in small group homes. In fact, many leading authorities feel that the traditional multipurpose residential model should be completely phased out and that alternative residential programs should be provided within the mainstream of community life. One strategy which has been successfully and economically adopted in some states is the transfer of residents to boarding houses and other group residences in the community, which are staffed by personnel who live on the premises. These homes may be terminal for less capable residents or they may provide a training setting for residents who can achieve independent living skills.

As retarded adults progress in occupational competence, they should be afforded opportunities to learn specific skills related to

semi-independent or independent community living. Programs of continuing education in these small group residences should focus upon general housekeeping skills, with the residents assuming primary responsibility for the cleanliness and neatness of their residence. Training should also be afforded in the purchase of household and personal items in the community shops and stores. The basics of personal safety and independent use of public transportation facilities, are other skill areas which should be emphasized. In this latter regard, it is important that the residents know the location of their home in relation to the rest of the community, and are able to communicate their addresses and telephone numbers to other persons. Knowledge of the laws and rules of the community is also important and should be reviewed periodically. Residents will further require continuing instruction in regard to personal appearance and hygiene, proper nutrition, exercise, and productive use of leisure time, to ensure their optimal social acceptance and adjustment to life in the community.

Yes	No	
☐	☐	**Does the institution have a clearly established plan for moving residents into the community?**
☐	☐	**Does the institution have available alternative living facilities in the community?**
☐	☐	**Are community group homes only considered terminal for residents who demonstrate abilities for independent living?**
☐	☐	**Are community living experiences designed to promote optimal independence and teach practical skills of daily living?**

Once residents have demonstrated their ability to hold a job, manage their affairs, and have mastered essential homemaking skills, they should be given the opportunity to reside in a supervised apartment living situation wherein they can further develop and practice independent living skills with diminishing supervision. Such a setting might be a small apartment building owned or leased by the institution. A live-in counselor should be available to provide general supervision (e.g., periodically checking to determine if housekeeping responsibilities are being met and safety precautions maintained) and to provide consultation as needed. However, independence should be stressed in housekeeping, food preparation, shopping, safety, etc.

The next step in the habilitation of institutional residents is placement in unsupervised living quarters. By this time they will

be gainfully employed and need only occasional support in the form of periodic counseling and guidance from community agency representatives regarding unusual events and problems. Another supportive strategy is found in the citizen advocacy programs which are being established in some sections of the country. The citizen advocate is a volunteer who may assist the retarded person in dealing with complex situations and will also serve as a friend and advisor. It is sometimes particularly difficult for residential institutions to relinquish control over the life of residents; however, as other citizens, they have a right to freedom from close scrutiny by social workers or other well intentioned but overly protective persons.

Yes	No	
☐	☐	**Are extensions of the group home setting available as a transition toward independent community living?**
☐	☐	**Are there supportive counseling services available to residents in the community?**
☐	☐	**Is the institution willing to relinquish control over the lives of former residents?**

RECREATION AND LEISURE TIME ACTIVITIES

Recreation programs should develop skills in two basic areas: physical motor development and social behaviors. As general mobility, sitting balance, and coordinated hand use emerge, the child will learn to occupy himself unattended for brief periods. The use of toys begins to take on increasingly repetitive patterns, and the child will play in the company of other children for extended periods of time. The functional use of toys becomes more evident as the child begins to engage in reciprocal play activities with other children, and the use of imagination, role playing and creativity are observed in familiar games of childhood. During this period, the constructive use of vehicles (e.g., tricycles) and playground equipment are particularly enjoyable. The next phase involves participation in games having increasing complexity in rules and social demands. Clubs and organizations (e.g., Cub Scouts) take on increasing importance, as does interest in organized athletics and, possibly, hobbies and crafts activities. At a later stage, organized heterosexual activities (e.g., parties and dances) take on greater significance as does the independent use of community recreational facilities.

The foundation for later recreation and leisure time pursuits must be laid during the earliest developmental periods. A first step is the encouragement of optimal responsiveness to familiar persons and events. Considerable individual attention including gentle handling, talking, singing, and playing with the resident are critical in order to encourage optimal responsiveness. This attention and stimulation should take place in daily care routines (e.g., bathing and feeding) and during later structured training sessions. No resident should be allowed to remain in bed throughout the day except in those extremely rare cases in which an unusual physical disorder (e.g., a severe cardiac problem) markedly restricts physical activities. Out of bed areas are needed in which the resident can move about, explore and interact with personnel and other residents. Floor mats and small rugs are commonly used for residents who are not yet capable of sitting or standing. Toys and other objects which attract the resident's attention are helpful in promoting purposeful movement, including reaching, grasping and coordinated hand use. Articles of furniture and other objects should be available to encourage the resident to pull himself erect and to stand and walk with support.

Yes	No	
☐	☐	**Do residents have daily opportunities for gentle handling, play, and personal attention from direct care personnel?**
☐	☐	**Are residents provided out of bed areas for crawling, mat-play, and other exercise of the large muscles?**

Yes	No	
☐	☐	**Are a variety of toys provided to stimulate and attract the attention of residents?**
☐	☐	**Does the environment have furnishings and objects which facilitate residents in pulling to a standing position and walking?**

Initially, the resident should learn to occupy himself unattended for brief periods of time. At this stage of play development grasping, banging and otherwise manipulating toys is highly common. Gradually, the resident will begin to use toys according to definite patterns (e.g., repetitive stacking, arranging and transferring objects). Residents should thus be provided with play objects offering a wide variey of shapes, sizes, textures and colors. At a more complex level, the resident will begin to use toys for the purpose for which they were designed. Residents should thus be provided with pull toys, dolls, play dishes and furniture, talking toys, etc. Residents should be encouraged to use these toys in play activities involving other residents. As increasing ability to cooperatively play with other residents is demonstrated, simple games may be introduced. This type of play helps to form the basis of later self-direction and impulse control. Daily play sessions should occur in the same location and at the same time of day in order to facilitate learning of time and place concepts.

The next phase involves the introduction of games which are increasingly complex in terms of rules and the social demands which they place upon the resident. Through such games, residents can be taught to wait their turn, carry out simple assignments, and imitate behaviors appropriate to a variety of social and work situations. They can further develop positive feelings about themselves through the manipulation of toys and the successful accomplishment of play requirements. Simple role play (e.g., dressing to play store or tea party) can serve to further social learning. The complexity of play activities should be appropriate to the resident's ability and interest levels.

Play should be thought of as a valid training activity and should be incorporated into the daily training schedule. A wealth of handbooks, guides and manuals describing games of varying levels of complexity are readily available. In addition to taking an active role in developing activity schedules, recreation staff should consult with living unit personnel on an ongoing basis to assist them in implementing meaningful play activity programs.

Yes	No	
☐	☐	**Do the play objects that are provided residents offer a wide variety of shapes, sizes, textures and colors?**
☐	☐	**Are residents encouraged to use toys purposefully in play activities with the residents?**

Yes	No	
☐	☐	**Is there a designated area for play activities?**
☐	☐	**Are play activities appropriate to ability and interest levels?**
☐	☐	**Is structured play made part of the daily training regime for residents?**
☐	☐	**Do personnel have access to description of games and other recreative activities?**
☐	☐	**Do recreation personnel train living unit personnel regarding recreative methods and techniques?**

Training for the resident in the area of gross and fine coordination should be incorporated in both indoor and outdoor recreational activities. Obstacle courses can be erected on the living unit which incorporate stairs, ramps, balance boards, cardboard tunnels, and other obstacles. Simple physical exercise routines can be introduced using balls, music games, trampolines and standard playground equipment. During playground periods, direct care personnel should not simply observe residents. Rather, they should take an active part in recreational activities and provide instruction in the appropriate use of playground equipment. Recreation staff can assist living unit personnel in this regard.

Yes	No	
☐	☐	**Are residents provided indoor and outdoor recreation and physical development activities?**
☐	☐	**Do direct care personnel participate in the instruction of residents regarding recreation activities?**

Habits of physical fitness and constructive use of leisure time are important to the physical well being and community adjustment of retarded persons. Calisthenics, coordination exercises, and organized sports should be a regular part of the resident's school and living unit schedules. Participation in formally organized goal-oriented groups such as the Cub Scouts and Boy Scouts can provide valuable learning in social skills as well as training in specific content areas. These groups also afford the resident the opportunity to learn basic leadership skills and to interact with adults and persons of his own age group in meaningful activities outside of the residential facility. Camping is another beneficial outdoor activity which provides numerous opportunities to learn skills related to independent living and self-protection. Activities such as ballroom and square dancing also offer healthful exercise and promote social

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interaction. Dances in the institution, however, should approximate those held in the community. It is not uncommon to see dances in which male and female residents sit in rows on opposite sides of the gymnasium or walk aimlessly about the floor in time to the music while the institutional staff sit or stand at one end of the building and observe. Dances should be aimed at developing appropriate social behaviors. Staff should, therefore, encourage sexual intermingling (male and female residents may be seated together at tables surrounding the dance floor) and should ensure that residents are taught to dance according to current styles.

Yes	No	
☐	☐	**Are calisthenics and organized sports included in resident training schedules?**
☐	☐	**Can residents participate in clubs and organizations?**
☐	☐	**Do social events provide an opportunity for residents to learn behaviors that are typically found in the community?**

Purposeful use of leisure time becomes particularly important during adulthood. Many mentally retarded persons, although proficient in work activities, fail to adjust to community living because they lack knowledge of recreational and leisure time outlets available in the community or they have not learned to independently use these outlets. As early as possible, residents should be taken on trips to the community and taught to use such facilities as swimming pools, bowling alleys, miniature golf courses and movies. As independence develops, residents should be encouraged to make use of these community resources in small groups, and then, independently. Hobbies and crafts can be a pleasurable means by which residents may occupy themselves in the institution, and may serve to prevent periods of loneliness and boredom in the community. Residents should be encouraged to develop an interest in crafts and hobbies, and should be allowed to engage in these activities in quiet and private surroundings.

Yes	No	
☐	☐	**Are residents assisted to identify and appropriately use community recreation facilities?**
☐	☐	**Is increasing independence encouraged in the use of community recreational resources?**
☐	☐	**Are residents encouraged to learn hobbies and crafts?**

SPECIAL PROBLEMS ASSOCIATED WITH MULTI-HANDICAPPED RESIDENTS

Some residents of residential facilities will have special training needs in addition to programs described in the preceding sections. These complex programmatic challenges necessitate the use of supplementary training programs, equipment adaptations, and architectural modifications. Regardless of these special programming needs, the multi-handicapped resident must not be unnecessarily segregated or otherwise denied the benefits of a comprehensive program appropriate to all residents.

All human beings experience an initial phase of being dependent and helpless. However, young multi-handicapped residents may experience an unusually extended period of dependency in proportion to their degree of mental retardation. To further complicate the problem, there is a tendency on the part of child care personnel to further prolong the dependency of multi-handicapped residents by treating them as infants or persons incapable of learning, growth, and development.

Institutional personnel must be given the opportunity to explore their own reactions to physical handicaps and to learn more about the nature and consequences of multi-handicapping conditions. If direct care personnel overreact to the physical disabilities or appearances of multi-handicapped residents, they will find it difficult to view the residents as human with developmental needs similar to all children. Furthermore, there has traditionally been an over reliance upon medical services for these residents, and while medical care is appropriate to a degree, the young multi-handicapped residents must not be deprived of needed training and adaptive techniques to overcome their physical handicaps and acquire educational, social and vocational skills.

Physical Disabilities

The necessity of intensive individual programs for young multi-handicapped residents cannot be over emphasized. Non-mobile individuals, especially those with severe retardation and physical handicaps may develop secondary physical disabilities if appropriate programs are not initiated at an early age. Being in bed, immobile, for prolonged periods of time may, for example, result in contractures, deformity, and extensive physical deterioration including decalcification of bones, atrophy of muscles, chronic respiratory infections and digestive tract dysfunction. Immobility also tends to impede intellectual development and may generate maladaptive psycho-social behavior. Therefore, therapeutic steps must be taken early in life to assure that multi-handicapped residents have appropriate developmental opportunities to avoid unnecessary intellectual, physical and social deterioration.

Because young non-ambulatory residents are experiencing physical growth, there is the need to ensure that additional physical

problems do not result from poor postures and positions assumed during periods in bed. It is common to find these residents further handicapped by "foot drop" resulting from long periods in bed without proper foot support or exercise. Such an abnormal foot position may eventually become "fixed" due to the shortening of tendons and muscle atrophy; however the condition can be prevented by providing periods of weight-bearing on the legs and feet each day and by placing shoes on the feet while in bed. Problems such as scissoring of the legs can be prevented by proper positioning exercise and the appropriate use of splints or leg restraints. Other common deformities of the head, rib cage and spine may also be prevented by correct body positioning and physical therapy.

The multi-handicapped resident should spend as much time as possible out of bed. The therapeutic team must carefully reevaluate medical problems periodically to assure that there is true medical justification for depriving residents of out-of-bed activities. In some institutions, residents who were heretofore considered "bed-fast", are now allowed mat play, sitting and ambulation experience (e.g., those with hydrocephalus or severe spastic quadraplegia). Rugs and mats can be used for residents who have not developed sitting balance. Ambulators, appropriately sized wheelchairs and other adaptive equipment can further make mobility possible and encourage the development of positional balance and motor coordination.

Yes	No	
☐	☐	**1. Are body positioning procedure and splints or other corrective devices used to prevent secondary deformities?**
☐	☐	**2. Do multi-handicapped residents spend a major portion of the day out of bed.**
☐	☐	**3. Is positional balance and motor coordination encouraged through floor mat activities, ambulators and appropriately fitted wheelchairs?**

Special adaptive equipment should be used to: (1) provide the individual a normal visual horizon and enhance the development of spatial relationships; (2) provide an increasingly normal opportunity for weight-bearing; (3) provide an opportunity to learn to control body position against gravity; and (4) permit the normal developmental progression from head balance, trunk balance, crawling, creeping, and finally standing.

Head balance can be accomplished in a number of ways. Tilting chairs have been commonly used to place residents at a sitting angle which will minimize head weight and provide a semi-upright position. However, the tilted chair, sometimes called a relaxation chair, is often grossly misused since it actually works against the child by preventing the development of trunk and balance. Another approach is to place residents in a prone position on mats in a

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stimulating environment which will encourage lifting and turning of the head. A wide variety of techniques are currently used to assist the development of head control, and these various approaches may be used with the same person at different times.

Old automobile tires have proven to be very valuable aids for encouraging trunk balance. A child can be placed in a sitting position inside tires that are padded with sheets. Such positioning maximizes the use of arms and trunk in developing balance. Pillows can also be used to prop a child while sitting on a floor mat. It is important to realize that the position of the child's hips and back greatly influence his ability to develop proper functional balance. Positioning restraints may also be used, provided they are properly applied in conjunction with other approaches.

Locomotion skills can be developed by placing the child in an environment which encourages crawling or creeping, and which also has objects he can use in pulling to a standing position. Crawling boards assist the child by allowing movement of the arms and legs. The standing table is frequently used to strengthen the upper and lower torso, while allowing the child to engage in educational or entertaining table activities simultaneously.

The environment in which non-ambulatory children reside may discourage or prohibit independent ambulation or other forms of locomotion. The residents are frequently grouped in living units resembling large hospital wards, which have no areas for out-of-bed activity. These large "ward-type" living situations are neither economic nor humane since they perpetuate the life-long helplessness of handicapped persons and increase the requirements for intensive nursing and medical care. When such conditions exist, special provisions must be made wherein equipment such as floor mats, rugs, ambulators, and child size wheelchairs ar brought to the children's living area and stored in separate areas while not in use.

Yes	No	
☐	☐	**1. Are a variety of techniques used to develop head control and sitting balance?**
☐	☐	**2. Does the environment promote crawling, creeping, rolling, pulling erect and strengthening of trunk muscles?**
☐	☐	**3. Is the living environment conducive to independent and other forms of locomotion?**
☐	☐	**4. Do the architecture and furnishing of the living simulate a home-like setting?**

The semi-ambulatory resident is often forced to be more dependent upon direct care staff than is necessary. The physically handicapped resident is often placed in an environment which is deficient in necessary aids such as straps, bars, and supports which will allow residents to transfer from wheelchair to beds, shower

or tub, and toilet. Moreover, mobility in a wheelchair often requires assistance since there are generally insufficient chair ramps to allow residents travel outside the building in which they reside. In this regard, all facilities should be constructed or remodeled to be barrier-free in accordance with the American Institute of Architects' statement on barrier-free environments.

One of the most important aids available to residents with ambulation problems is the wheelchair. It is absolutely necessary that wheelchairs fit the body size and other physical characteristics of residents. Also, adaptations such as foot rests, arm rests, head rests, and seat belts may be indicated. Through the proper use of restraints, weights, posturing devices, and trays on wheelchairs, many residents can evidence capabilities which otherwise are not realized.

Physically handicapped residents should never be considered unable to develop self-help and mobility skills. It is more appropriate to assume that there is no limit in the degree to which a given resident can learn, if proper training programs are devised. The use of prosthetic aids are particularly important in the classroom. With appropriate training and adaptive devices the residents are further capable of making a satisfactory adjustment in sheltered workshops or in the production of salable items.

Yes	No	
☐	☐	**1. Are straps, bars, ramps, and supports used to promote independent use of living unit facilities by residents in wheelchairs?**
☐	☐	**2. Do wheelchairs fit the body size and physical characteristics of residents?**
☐	☐	**3. Are prosthetic aids used to maximize the educational and work capabilities of multiply handicapped residents?**

Epilepsy

Epileptic seizures may complicate the training of residents by generating attitudes of fear and over-protectiveness on the part of child care personnel. Seizures result from abnormal electrical discharges in the brain which lead to general neural dysfunction. This uncoordinated activity may remain in one area of the brain or spread to other areas causing marked physical manifestations including loss of consciousness, tightening and jerking of muscles, and breathing irregularities. Certain children, especially those who have Petit Mal attacks, may only experience sudden, brief lapses of consciousness which last for several seconds. Because of the rapidity of such seizures, the resident's condition may be unrecognized, and teachers or other persons may interpret the resident's

behavior as day dreaming or inattentiveness. A third form of epilepsy involves the periodic display of repetitive movements with accompanying states of confusion.

Seizures may be precipitated in epileptic residents by a number of conditions and factors including rapid breathing, certain patterns of visual stimulation, and emotional tension. However, recent advances in the use of anti-convulsant medications have made possible the control of seizures for many residents. Since no two children will respond in exactly the same way to medication, the physician will prescribe a drug, or combination of drugs, and gradually increase or decrease the dosage in order to determine the proper amount for each resident. To be effective, the medications must be given as prescribed, with no dose being missed. Furthermore, the resident's medication program should be reviewed periodically to ensure they are receiving appropriate therapy. In this regard, the over use of tranquilizing drugs and some anti-convulsants may constitute chemical restraint, the effects being similar to keeping the resident in a straight jacket and preventing him from learning and developing. There may also be dental problems associated with the use of some anti-convulsants, particullarly Dilantin. Therefore, epileptic residents should receive regular dental treatment to minimize undesirable side effects.

Many individuals erroneously believe that they should insert something in the mouth of residents during an epileptic seizure to prevent swallowing the tongue, which in most cases is highly unlikely. Attempting to insert objects between the teeth during a convulsion is dangerous and likely to result in serious dental damage. It is more important for the observer to do his best to prevent injury to the resident during the attack. Tight clothing should be loosened, especially about the neck. Some residents will be able to recognize when a seizure is about to occur and they can be assisted to a safe place to avoid falling on sharp objects. Physical restraint should never be used because it will increase the violence of movement and result in strained or wrenched muscles.

Epilepsy is rarely a sufficient reason for restricting the activities of retarded residents, or excluding them from training programs provided other residents. Commensense precautions should be followed with respect to such activities as crossing streets, riding bicycles, or swimming. Otherwise, these residents need educational and group experiences as much as anyone else, and should be encouraged to participate in appropriate activities.

Yes	No	
☐	☐	**1. Are records available which indicate regular medication review?**
☐	☐	**2. Have personnel been trained in the procedures to be followed when residents have seizures?**

Yes No

☐ ☐ 3. **Are epileptic residents allowed full participation in training, social and recreational activities afforded non-epileptic residents?**

Visual Disability

Because the number of visually impaired residents is usually small in any given residential institution, they are frequently forced to live with sighted residents and denied special training opportunities. In such settings, the blind resident may exhibit marked psycho-social withdrawal and become increasingly dependent and physically debilitated. The answer to these problems is not necessarily segregation; however, some residential institutions have established living units exclusively for blind residents. Even here, problems are encountered with heterogenous grouping in that the blind residents usually function at different developmental levels. In many respects, it might be preferable to modify the dormitories of sighted residents to accommodate the blind residents having similar intellectual levels, and provide special training activities to supplement regular dormitory and school programs.

The architectural features and furnishings of dormitories housing blind residents should encourage mobility and self-care. Textured material can be used to facilitate recognition of certain locations or parts of the building; and furniture, partitions, and other obstacles can be arranged to provide free traffic flow to frequently used locations. Special areas on the dormitory and playground are particularly needed for withdrawn or fearful residents in order that they may be encouraged to explore their surroundings without interruptions, by unexpected strangers, unfamiliar or loud noises, and other potentially aversive stimuli.

Most programs for blind residents begin with body image training. The residents' hands are guided to specific parts of the body, usually starting with the major body areas and proceeding to more detailed parts as the resident progresses in recognition. Next, training usually focuses upon identification of sensory stimuli. The child is presented such stimuli as wood, metal and cloth; hot water and ice cubes; objects of different shapes and weights; and other articles which contrast sensory differences.

Another important area of training related to later independent mobility is teaching the blind resident the relationship of his body to the rest of the environment. Normal routines of sitting and standing as well as other physical activities can be used to teach the differences between up and down, over and under, around and through, inside and outside, and right from left. Considerable information and explanation regarding common objects which will be encountered and their relationship to one another will be needed to promote confidence on the part of residents.

Mobility is usually encouraged initially through the use of a

sighted guide, and later, guided-cane travel is introduced. The sighted guide should never pull the blind resident, but gently grasp the resident's elbow and walk naturally to the desired location. Self-protective behaviors further need to be taught during the initial phases of mobility training. Instruction regarding environmental forms, patterns and positions should be incorporated throughout the process. At this stage in training, residents should be actively involved in self-care and other dormitory programs. As independent mobility and self-help improves, the resident should proceed from indoor to outdoor cane travel. His travel experiences should then be further extended from the institutional grounds to the community.

Finally, special attention should be given to teach proper posture and gait. Unguided trial-and-error on the part of residents frequently causes them to develop abnormal postures and gaits characterized by slumping, everting feet, foot slapping, and short shuffling strides. Such abnormal body positions can be corrected by providing the resident with appropriate information and correct practice.

Yes	No	
☐	☐	**1. Are visually impaired residents allowed to live with sighted residents of comparable age and ability level?**
☐	☐	**2. Is the living unit arranged and furnished so as not to hinder the mobility and self-care functions of blind residents?**
☐	☐	**3. Are special sensory training and mobility programs available for blind residents to supplement other residential training programs?**
☐	☐	**4. Are mobility programs for blind residents designed to increasingly encourage independent travel, both in the institution and in the community?**

Hearing Disability

The deaf or hard-of-hearing resident presents a unique problem in that a major sensory contact with his environment, that of auditory stimulation, is absent or lessened. Without this primary signaling or warning sense, he must rely heavily upon his other senses in adapting successfully to his environment.

When constructing a suitable environment for these deaf residents, it should be remembered that these individuals will be dealing with all of society, not just the deaf population. Thus, the environment should be as similar to that of the hearing world as possible. Many deaf individuals do have some residual hearing which should be utilized to the fullest extent. In addition, the deaf are sensitive to visual as well as tactile stimulation, and would be receptive to a brightly colored environment as well as one that

employed materials and objects of many different textures. Good lighting should further be provided in order that effective use of visual clues can be assured. Moreover, the environment for these residents should be designed to promote "visual listening" through maximizing interpersonal visual contact.

Programming efforts should be supported through consultation and training by specialists knowledgeable of techniques and methods of handling individuals with learning losses. These specialists might be trained in deaf education, speech pathology, or audiology. Methods of dealing with the deaf have ranged from an approach of strictly manual communication, or sign language, to one of pure oral communication. Currently, the most widely accepted approach is to use a combination of the two techniques according to individual resident needs.

Early intervention is necessary for a successful programming. If training can begin during the preschool years, there is better prognosis for communication development, socialization, and adequate adjustment in the hearing world. Many educators have found that special early education programs exclusive for the deaf facilitate training. As the children begin to learn techniques for combining auditory with visual clues, such as lipreading and facial expressions, they are incorporated into classes with hearing children, wherein they are taught behavior necessary for life in the hearing society. Isolation of deaf residents, either physically or through teaching sign language exclusively, would be extremely detrimental for adequate adjustment.

Prior to program planning, residents should be evaluated to determine their degree of hearing loss, need for medical intervention, need for amplification, and type of amplification that would be most beneficial to the individual. If it is determined that residents will benefit from sound amplification, the proper device should be selected. In some cases a hearing aid is chosen to fit the characteristics of the individual hearing loss. In others a microphone-headset type of amplification is used. In either case, special training is needed not only in the care and maintenance of the amplification device, but also in the most effective ways of using the device to its maximum efficiency.

Yes	No	
☐	☐	**1. Are deaf residents provided a living environment which will promote normal patterns of daily living?**
☐	☐	**2. Are manual and oral communication methods used according to individual resident needs?**
☐	☐	**3. Are special communication training activities used to supplement other educative programs for deaf residents?**
☐	☐	**4. Are a variety of amplification devices available to deaf residents?**